Report on an inspection visit to police custody suites in Lambeth Basic Command Unit

15 – 17 June 2009

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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

Ashley House
2 Monck Street
London
SW1P 2BQ
England

Contents

Appendices

1. Introduction

This inspection of police custody suites in the London Borough of Lambeth is part of a programme of joint work by HM Inspectorate of Constabulary and HM Inspectorate of Prisons. They contribute to the United Kingdom's compliance with its international obligations to ensure regular independent inspection of all places of custody[1]. In each inspection, we examine force-wide strategies, treatment and conditions, individual rights and healthcare.

Lambeth has three custody suites, Brixton, Kennington and Streatham, designated under the Police and Criminal Evidence Act (PACE) 1984 for the reception of detainees. All three suites are open 24 hours a day and may hold adults, juveniles and immigration detainees. Some 7,000 detainees were held in the six months preceding the inspection. As well as visiting the suites, inspectors interviewed a sample of prisoners at HMP Brixton who had previously been detained in the Lambeth suites.

Strategic management was provided by the custody directorate of the Metropolitan Police Service (MPS), with day-to-day management devolved to the borough commander and his staff. The custody directorate operated an internal inspection function. Responsibility for the custody estate lay with the Metropolitan Police Authority (MPA). The MPA did not have a single custody lead, but one official did manage the Independent Custody Visitors (ICVs). The ICVs reported professional relationships with custody managers and staff in Lambeth, and felt that the borough was responsive to their concerns.

There were good partnerships with health service providers and the Crown Prosecution Service (CPS), although the police were concerned that a shortage of lawyers was impacting on CPS effectiveness. The majority of staff were well trained, although most were not permanent, with police officers posted into custody roles. There was also a lack of familiarity with the 'lessons learned' material produced by the Independent Police Complaints Commission (IPCC).

We were concerned to find inconsistencies in the use by custody staff of appropriate adults to safeguard vulnerable adults with mental health. Staff also, on occasions, found it difficult to access this support. There were also technological and procedural failures in the use of closed-circuit television (CCTV) at Brixton and significant weaknesses in the storage of forensic samples at Kennington. These shortfalls, in important mechanisms that protect individual rights and afford corporate assurance, needed to be addressed urgently.

Custody staff were observed to be generally respectful and sensitive in the treatment of detainees. The three suites were well maintained and efforts were made to get rid of graffiti. However, showers were rarely offered and only paper towels were available. Toilet paper and hand washing facilities were available only on demand. There was also little privacy when booking in and no cells were adapted for those with disabilities.

With the exception of protection for vulnerable adults, appropriate attention was given to ensuring detainees' entitlements under PACE. Local court cut-off times and a lack of video link facilities hampered expeditious processing of detainees. The quality of custody records varied and arrangements for making complaints needed to be improved.

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

The quality of health services was mixed and custody staff expressed some concerns, including the slow response times of some forensic medical examiners (FMEs). Some FMEs could not access all necessary medical records, the quality of record keeping varied and FMEs also lacked basic equipment. Medicines management was good. Drug services were well structured, but were not sufficiently integrated into the work of the custody suites and no services were available for those with alcohol problems. Effective support was provided by the local mental health trust.

Custody suites in the London Borough of Lambeth receive large numbers of detainees with a wide range of risks and needs. Managers and staff generally responded well to these challenges, but this inspection also identified a number of areas requiring improvement. In particular, there were weaknesses in the treatment of vulnerable adults, the use of CCTV and the storage of forensics. These issues require urgent attention, both to protect individual rights and also to afford corporate assurance that appropriate checks and balances are in place. We hope this inspection assists the borough to continue to improve its custodial arrangements.

Denis O'Connor
HM Chief Inspector of Constabulary

Anne Owers
HM Chief Inspector of Prisons

October 2009

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have begun 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 do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes. They are also informed by *Expectations* 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 Police and Criminal Evidence Act 1984 for the reception of detainees. Twenty-five are 'overflow custody suites', used for various operational matters such as charging centres for football matches or immigration detention. One suite is used for Operation Safeguard (overflow from prisons) when needed. The remaining 51 custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.

2.3 This inspection was conducted in the three custody suites in the London Borough of Lambeth. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and healthcare in the three suites. A survey of prisoners at HMP Brixton who had formerly been detained in Brixton, Kennington or Streatham custody suites was conducted by HM Inspectorate of Prisons researchers and an HM Inspectorate of Constabulary staff officer to obtain additional evidence (see appendix III).

2.4 All three custody suites were open 24 hours a day and held adults, juveniles and immigration detainees. Between October 2008 and March 2009, they had received 7,000 detainees, an average of 38.5 each day. This included 980 juveniles, 926 women and 227 immigration detainees.

Strategic overview

2.5 Strategic oversight of custodial facilities within the MPS is provided by a custody directorate within the Operation Emerald territorial policing team led by a commander, with day-to-day management delivered by a detective superintendent. The custody directorate has an internal inspection function. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs. Responsibility and accountability therefore rested with the borough commander, who was an acting chief superintendent.

2.6 The Metropolitan Police Authority (MPA) had responsibility for the custody estate, but did not specifically allocate portfolios of responsibility to members of the MPA and, as such, there was no defined MPA lead for custody. The MPA did, however, have an official who managed the Independent Custody Visitors (ICV) scheme and had lead responsibility for reporting on custody issues. The borough was responsive to issues raised by ICVs. There was also a MPA member-led panel that reviewed and led on the custody suite building programme.

2.7 The MPS's asset management plan had stalled due to the wider economic situation, which had led to a 'rephasing' of the building plans. Lambeth did not know whether the planned new suite at Brixton would go ahead, but was making best use of the accommodation available. The staffing model offered a permanent custodial staff team at Kennington, but not at Brixton or Streatham.

Treatment and conditions

2.8 The custody suites varied from the very busy (Brixton) to the relatively quiet (Streatham), but all detainees were treated respectfully and sensitively and had their rights and entitlements explained. Detainees' diverse needs were identified through risk assessment, including the specific needs of women, carers and young people, but these were not always subsequently taken into account. All staff had been trained in 'Every Child Matters' and had an understanding of the needs of juveniles, but the lack of any MPS-wide or local guidance on how juveniles should be cared for in custody led to inconsistencies. Staff were trained in, and confident about, managing issues around self-harm and suicide. Kennington and Streatham police cells had conducted fire evacuation drills in 2009.

2.9 There was a lack of privacy in booking in areas and names and offences were listed outside cells at Brixton and Kennington. Explanations about how to use cell call bells varied, but response times were good. Cells contained mattresses and pillows, and blankets were available. Women could ask for hygiene products, but this information was displayed in English only. Underwear was not provided. There were toilets in every cell, but toilet paper had to be asked for and detainees could not wash their hands. There was no shower at Streatham, making the holding of immigration detainees there wholly inappropriate. There was little evidence in the other suites that showers were taken and anyone taking one had to dry themselves with a paper towel. There was good oversight of maintenance of the police cells, and communal areas were generally well maintained. Work to reduce the amount of graffiti in cells was under way.

2.10 Visits were not allowed and there was no exercise area, but detainees could use the small caged arrival areas on request to get some fresh air depending on staff availability. All suites were no smoking, but detainees did not appear to be offered nicotine replacement aids. Little was provided to pass the time, despite the availability of reading material. Detainees were offered food and drink. The food was good quality.

Individual rights

2.11 Detainees could access solicitors, but solicitors reported difficulties contacting the suites by telephone. Kennington did not have enough interview rooms. The appropriate adult scheme (TAAS) was unresponsive and did not support vulnerable detainees. We remained concerned that 17 year olds were excluded from PACE protections for juveniles. Detainees could notify someone of their detention, but telephone calls to them could not be made in private. They were asked about dependency obligations and issues were addressed if they remained in custody. A telephone interpreting service was used at Brixton and Kennington, but not Streatham. Interpreters were more commonly used, although this was problematic during unsocial hours. Sign language interpreters were available. Reasons for detainees remaining handcuffed in the custody area were not always recorded and instances of use of force were not monitored or analysed. Interviews were carried out within PACE guidelines, but the 2008 amendments to the PACE code were available only at Brixton.

2.12 The storage of forensic swabs at Kennington was deficient and required urgent attention.

2.13 There were no video links for court appearances and court cut-off times were early and resulted in unnecessarily lengthy detention. Procedures for complaints and racist incident reporting were poor.

2.14 Record-keeping was underdeveloped. Pre-release risk management was uncoordinated, with no specific policy, although staff offered support to juvenile and vulnerable detainees on release from custody. They also made referrals to appropriate external agencies.

Healthcare

2.15 The quality of health services was mixed. Forensic medical examiners' (FMEs') rooms were clean and tidy, but did not offer privacy. There was a lack of basic medical equipment, so doctors brought what they needed with them. Medicine management was good. There was no overstocking of medication. Methadone prescribing was inconsistent. Fridges in the FME rooms were properly maintained and there were no forensic samples in them at the time of the inspection.

2.16 Medical services were provided by Forensic Medical Services (FMS). Custody staff expressed concern about the standard of service delivery. There was evidence that response times were poor, but there was no reporting or monitoring of this at a local level. Some FMEs could not access the NSPIS system and we had concerns about medical confidentiality and the consistency of information available. Drug services were well structured, but workers did not attend custody suites other than by request and worked in isolation. There was no provision for alcohol users, who were simply signposted to local services.

2.17 The relationship between mental health workers and custody staff was good. There were regular meetings between South London and Maudsley (SLAM) mental health trust and a designated senior police liaison officer. Arrangements for the management of detainees under Section 136 of the Mental Health Act were good and there was a dedicated '136' suite at Lambeth hospital.

3. Strategy

3.1 The MPS had a custody directorate led by a commander. Day-to-day management was delivered by a detective superintendent. There was an internal inspection function. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and accountability therefore rested with the borough commander, who was an acting chief superintendent. There was no defined MPA lead for custody, but a MPA official managed the independent custody visitors scheme and had lead responsibility for reporting on custody issues.

Expectation

3.2 There is a policy focus on custody issues at a chief officer level.

Findings

3.3 The territorial policing commander was the chief officer lead on custody for the MPS. The custody directorate had an inspection function: one police inspector and one health and safety officer had individual responsibilities for audit and inspection, health and safety and the implementation of 'guidance on the safer detention and handling of persons in police custody' (SDHP). The commander sat on the programme board for SDHP and was clearly focused on professionalising custody. He was also looking towards and planning for integrated prosecution teams and the use of virtual courts in the new custody suites.

3.4 Strategic policies were signed off at a strategic command level within the MPS and the custody directorate provided standard operating procedures (SOPs) that supported delivery of force policies by custody suites in each London borough. The SOPs covered a broad spectrum of matters, such as use of police custody, use of closed-circuit television (CCTV) and guidance to custody staff on the supervision of detainees. The SOPs were designed to assist boroughs to deliver consistent levels of service, although responsibility and accountability for their delivery had been delegated to borough commanders.

3.5 The MPS had recruited its first team of nurses to complement the level of healthcare provided by its doctors, although none of these were yet working in the Lambeth borough. It aimed to recruit 200 nurses by 2012 with a view to ensuring each borough had an on duty nurse 24 hours a day. Clinical governance was being revisited with a view to employing a member of staff full time.

Expectation

3.6 There is an effective management structure for custody that ensures that policies and protocols are in place and implemented and that there are mechanisms for learning from adverse incidents, rubbing points or complaints.

Findings

3.7 Lambeth borough had three custody suites spread over two sub-unit command areas of north and south, with a pan-borough command that dealt with operational support units. Brixton was the main custody suite, with 15 cells, three of which were detention rooms. The borough was due to move from a geographically based model of policing to a functional line management model, but this was being held in abeyance until the new permanent borough commander arrived on 29 June 2009.

3.8 There were two other custody suites at Kennington and Streatham. Streatham was used as an overflow facility or for immigration detainees on behalf of the UK Border Agency (UKBA). All custody sergeants and designated detention officers (DDOs) had received nationally accredited custody training, and police constable (PC) gaolers had received some locally delivered custody training before their deployment into custody suites. Custody training for sergeants and DDOs was delivered corporately. Custody training for PC gaolers was delivered at borough level as part of a training cycle or developmental training as a probationer constable.

3.9 The majority of staff had also received additional mandatory custody-specific training during October/November 2008. This included first aid, mental health, self-harm and suicide training. This was a very welcome departure from our normal findings. The custody teams were not permanent teams, with police officers 'posted' into the roles, although unusually Kennington used permanent staff for day and evening shifts and staff from patrol sections for the night shifts. The acting borough commander believed a move towards a dedicated operational command unit that centrally managed custody on behalf of boroughs would be a progressive one as it would help professionalise the provision of custody services.

3.10 While some custody records contained an impressive amount of detail, the level of record-keeping in others was poor, indicating that some staff had failed to take the Independent Police Complaints Commission (IPCC) 'learning the lessons' circulars on board. We identified serious concerns around how some sergeants approached the issue of vulnerable adults, their recording of risk assessments regarding them and difficulties with sometimes accessing an appropriate adult. We asked the MPS to review one investigation over concerns we had about a possible miscarriage of justice where the legal safeguards concerning a vulnerable adult may have been breached. Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating adverse incidents.

3.11 The acting borough commander felt that strong local partnerships existed with the NHS hospitals at Guy's and St Thomas', at which dedicated officers were based. The primary care trust attended working groups, including one on mental health and one looking at enhancing the level of information exchange. The acting borough commander believed there were good relations between the police and drugs intervention programme (DIP) staff and drug action teams (DATs), who had strong links with the custody suites, but we did not find this to be the case (see paragraph 6.29).

3.12 The acting borough commander said that work was already under way to base an integrated prosecution team at Brixton Police Station. The acting borough commander had held two meetings with the Crown Prosecution Service (CPS) branch crown prosecutor in relation to the review and timeliness of prosecution files in respect of serious matters, but he stated the CPS was short of lawyers and had reduced its face-to-face service to two days a week, which affected the service it could provide. It had recently reinstated a lawyer at Brixton who carried

out one-to-one advice on weekdays. Police officers and the CPS were aware of the escalation process for resolving cases in dispute, although it was not commonly used because disputes tended to be resolved locally.

3.13 The acting borough commander was not aware of any forum where concerns from defence solicitors could be raised with the police, although defence solicitors sat on the local criminal justice board. Solicitors said relationships with the police were patchy and some custody staff were not helpful. As an example, they described one custody sergeant at Brixton who robustly refused to provide them with copies of the custody record until the detainee had been charged, while other stations and other sergeants at Brixton allowed them free access to custody records. This position had been rectified before the end of the inspection.

3.14 There was a MPA lead for the independent custody visitors (ICV) scheme, which provided an important independent oversight mechanism. ICVs reported professional relationships with the police at Lambeth. They visited the custody suites regularly and held regular ICV panel meetings where issues of concern were addressed by the police. The ICV coordinator met the custody directorate every six weeks. ICV reports were regular and clearly focused on prisoner standards and welfare, with ICVs prepared to seek assurance on issues of concern. There was a system of recording these concerns and a formal mechanism for feedback.

3.15 A dedicated professional standards department based at borough headquarters collated and managed the complaints from Lambeth borough and fed back to the borough senior management team details of the number and type of complaint made.

3.16 We made enquiries into specific allegations about the treatment of detainees who had been in custody at Lambeth borough. Custody records were examined in detail and cross-referenced with CCTV recordings where appropriate. In one case, a copy of a CCTV recording from March 2009 could not be found and we subsequently established that the CCTV system at Brixton, while working correctly, had not had the CCTV tapes replaced in the video recorders as required. We were told by staff that there had been a period of three weeks in March 2009 when there were no CCTV tapes available for review following a critical incident or serious complaint, although the force subsequently claimed that this had been only one week. That this went unidentified for so long called into question the robustness of the quality assurance systems and the management of them. It was also a clear breach of the MPS's own policy on the management CCTV in custody suites.

3.17 When we asked to view a second CCTV tape, two viewing computers repeatedly failed to recognise the format of the tape, which therefore meant the tape had to be sent to a laboratory for further analysis. This was less than ideal and again called into question the reliability of the current system. In the event of a critical incident in custody, the inability of the MPS to produce a CCTV tape for whatever reason could be viewed with deep suspicion by parts of the community that lack confidence in the police and could exacerbate a situation unnecessarily. The laboratory copy of the tape subsequently provided demonstrated a proportionate, well-managed and professional use of force, which highlighted the importance of the MPS being able to provide CCTV evidence for viewing.

Recommendations

To the Metropolitan Police Service

3.18 To ensure the implementation of corporate policies and the maintenance of corporate standards, the Metropolitan Police Service should consider putting the management of all custody suites under one operational command unit.

3.19 Police officers and staff should access the 'lessons learned' circular from the Independent Police Complaints Commission.

3.20 The Metropolitan Police Service should engage with relevant partners to ensure that there is an effective appropriate adult scheme in operation for both vulnerable adults and juveniles.

3.21 The old closed-circuit television system at Brixton should be replaced by an up-to-date digital system.

3.22 The quality control systems in place to govern the storage and tracking of closed-circuit television recordings should be reviewed, with new robust systems replacing the current flawed ones.

To the Metropolitan Police Authority

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

4. Treatment and conditions

4.1 Maintenance work was well organised and monitored. Recent fire drills had been held at Streatham and Kennington. Not all designated detention officers had received fire safety training. Detainees were asked a range of questions addressing some of their diverse needs. Not enough was done to promote the availability of religious material. Custody staff had a good understanding of the needs of children and young people and had received relevant training. Risk assessments were used to determine levels of observation required and how safely to manage detainees in custody. Custody suites were in reasonable condition, but Streatham had no showers and Kennington contained potential ligature points. Meals were satisfactory. The range of reading material was poor. Exercise areas were restricted and not used consistently. Clothing provided was acceptable, but unsuitable to wear on release or for court appearances. Stocks of clothing at Brixton were low. Detainees were not allowed social visits.

Expectation

4.2 The custody suites are properly maintained and ongoing maintenance work does not have a negative impact on the treatment and conditions of detainees.

Findings

4.3 Each of the three custody suites had similar mechanisms to monitor and address necessary maintenance. The designated detention officers (DDOs) checked cells daily, including for ligature points, cleanliness of communal areas and first aid equipment. There was a further daily inspection by the custody sergeants and a handover checklist was completed at the change of shifts. All custody sergeants we spoke to had a good oversight of the overall fabric of the cells and detention rooms and any pending maintenance work. At Kennington, the inspector conducted weekly checks of the cells, drugs cabinets and general custody area and the superintendent completed weekly inspections. Good records of these maintenance inspections were retained.

4.4 Cells and communal areas were cleaned daily (twice daily at Kennington) by the contracted cleaning service and there was a clear process for reporting any required maintenance that might result in taking detention cells out of use. Reports went to the contracted maintenance service, which categorised the urgency of each job. The contactors were guaranteed to attend the custody suite within two hours when maintenance work might have placed a cell out of use.

4.5 One cell at Kennington police station was out of use and a second detention cell was used only during daylight hours because the toilet area did not have a working light. Records showed that this had been reported to the contractor, who had given an estimated response time of within 12 hours.

Expectation

4.6 Custody suite staff can safely evacuate the custody suite in the event of a fire.

Findings

4.7 At Brixton, fire evacuation information was displayed in communal areas and fire exits were clearly identified. Custody sergeants had received fire safety training, but DDOs were given an informal talk about evacuating the building. The fire maintenance log did not record that any fire evacuation drill had been conducted and the custody sergeants were not aware whether a drill had been conducted in the year to date. All staff we spoke to were aware of the evacuation procedures, where extra handcuffs were stored and who the responsible fire safety officer was during a fire evacuation. A fire alarm check was conducted during the inspection.

4.8 Kennington had held a fire evacuation drill in February 2009 and an actual fire evacuation in May. Details of both were recorded in the fire maintenance log. Cell keys and handcuffs were visible to custody staff and the fire exits and fire evacuation route were clearly displayed on the wall. The entrance and exit to the custody suite were via a ramp and accessible to most people with mobility difficulties, although there was a small step to negotiate. Staff said detainees could be taken out of the custody suite through the front of the station if necessary. One of the DDOs we spoke to had been in post for a month and the other for five years, but neither had received formal fire safety training.

4.9 A practice fire drill at Streatham on 1 June 2009 was recorded in the fire maintenance log. All the custody sergeants received fire safety training, as had the DDO on duty. Custody staff knew the location of the fire evacuation point. All those evacuating from the custody suite to the rear yard had to negotiate some steps. Staff said anyone with mobility difficulties could use the front entrance to the station, but would still have to manage some steps, albeit fewer of them.

Expectation

4.10 The diverse needs of detainees are met. This includes the specific needs of:
- Women
- Black and minority detainees
- Foreign nationals
- Those with a disability
- Immigration detainees
- Those with different religious needs

Findings

4.11 The booking-in process included a generic risk assessment used for all detainees that addressed a range of diversity issues. Foreign national detainees were advised of their rights and entitlements and were asked if they wished to contact someone from the consul of their own country. Female detainees were given the opportunity to speak to a female member of staff. All detainees were asked if there was anything else that might affect them while in custody, but the custody sergeant did not indicate what issues might be relevant and none of those we saw being booked in declared any.

4.12 Detainees were given very little opportunity to discuss any religious needs. All three custody suites held a range of religious materials, but detainees were not routinely informed of this. We saw one detainee at Brixton provided with a Koran and prayer mat. Detainees were asked about any medical, physical or mental health issues, but none of the custody suites was equipped to meet the needs of detainees in wheelchairs or using walking aids.

4.13 When busy, the small waiting areas in each custody suite did not provide detainees with any privacy to discuss specific needs. There was no control over the number of people, particularly officers, appropriate adults and police personnel, allowed in the custody suite while detainees were being booked in.

4.14 All custody suites had good access to translated information and custody records showed that interpreting services were used. The custody suites were located in particularly diverse communities and there was a diverse range of staff. DDOs were aware of the range of needs of different detainees and were responsive to these and respectful.

Expectation

4.15 All custody staff recognise and understand the distinctive needs of children and young people.

Findings

4.16 Custody sergeants and DDOs had received training in the Children's Act 2004 (Every Child Matters) in the previous year.

4.17 There was no consistent approach to whether appropriate adults could stay with juveniles in a holding room. Staff in all three suites said that in exceptional circumstances the juvenile would be allowed to wait with an appropriate adult in the main waiting area if it was quiet.

4.18 Custody staff were aware that information had to be explained and understanding checked more rigorously with juveniles. All juveniles were observed at least every 30 minutes and there was a consensus across the suites that juveniles should not remain in custody any longer than necessary. There was evidence that young people were bailed at the earliest opportunity.

4.19 Custody sergeants and DDOs knew the process for reporting child protection issues. Custody sergeants at Brixton and Kennington said that all staff, including from partner agencies, had received an enhanced Criminal Records Bureau check before starting work at the station.

Expectation

4.20 All custody staff treat children and young people according to their distinct needs.

Findings

4.21 All staff knew that children and young people should be located in the detention rooms, which were no different to other cells apart from being near the custody desk. Brixton had three detention rooms (two for male juveniles and one for female juveniles), Kennington had two and Streatham had one. All staff were aware of the need to contact an appropriate adult, whether parents, carers or through the appropriate adult scheme. DDOs in all three suites said they would not allow juveniles to be placed unsupervised in a waiting area with adults and that any use of the facilities or time out in the fresh air would take place individually.

4.22 Brixton was the only custody suite holding juveniles during the inspection. Staff there treated them respectfully, making regular checks to let them know what was happening and to offer refreshments. When outside the detention rooms or cells, juveniles were supervised by DDOs. All juveniles we spoke to confirmed that they had been treated reasonably well at Brixton.

4.23 Custody sergeants at all three suites said children and young people were strip-searched only in the presence of an appropriate adult and that the purpose of all searches, including simple pat-down searches, was fully explained. The juveniles held at Brixton had received a pat-down search and confirmed that the reason for this had been explained.

4.24 The three juveniles at Brixton also confirmed that they had been brought into the custody suite in handcuffs, but that these had been removed at the front desk. Two were located in detention rooms and one in a cell. Staff said juveniles were placed in any of the cells following a risk assessment when the detention rooms were full.

4.25 None of the juveniles had been given a leaflet explaining their rights and entitlements, but all had been told about them. An appropriate adult had been contacted in each case and the juveniles knew what was going to happen next. When appropriate adults attended the station they were not allowed to wait with the juveniles in the detention room, but remained in the main waiting areas.

Expectation

4.26 Custody staff are respectful in their day-to-day working with detainees.

Findings

4.27 Most staff were organised, polite and professional. In the interactions we observed, DDOs were largely respectful towards detainees and responsive to their needs. Most detainees we spoke to said they had been treated reasonably well in detention. Detainees at Brixton and Kennington were referred to either by first name or title and family name. However, in both suites, detainees' names and offences were listed outside cells. At Streatham, DDOs and custody sergeants referred to detainees by cell location. Even though this was not done in front of detainees, it was not appropriate.

4.28 We observed one detainee at Brixton becoming frustrated having spent the night in a cell. The DDO spoke to him and allowed him to have his meal in the waiting area so that he could have some time out of his cell.

Expectation

4.29 Custody staff have the skills and competencies to manage detainees at risk of harm to themselves.

Findings

4.30 Most staff had received additional mandatory custody-specific training, which included self-harm and suicide. All custody staff carried anti-ligature knives and their response to an incident of self-harm would be to notify the custody sergeant before taking any action. Cell keys were held at a central point behind the custody desk and were not carried by DDOs.

4.31 Detainees were risk assessed for potential to self-harm. They were asked direct questions about present or historical self-harm and any suicide attempts or thoughts. Custody sergeants took into consideration whether detainees were under the influence of alcohol or drugs and checked any historical information on NSPIS. Custody sergeants at Brixton and Kennington checked detainees' arms if they had saw signs of self-harm or were concerned.

4.32 If a detainee was unwilling to engage with the risk assessment, custody sergeants tried to gather information from NSPIS and used their own observations, and the level of monitoring was increased until they were satisfied the detainee was not at any risk of self-harming. However, staff at Streatham gave contradictory information about how they would manage a detainee who would not engage with the risk assessment process.

4.33 At Brixton, two detainees were placed on a constant watch with an officer outside each cell and the door open. One of the officers interacted well with the detainee and the second observed the detainee, who was under the influence of alcohol and mostly sleeping. In both cases, the forensic medical examiner (FME) attended and both detainees were flagged on NSPIS as at high risk of self-harm so it was obvious to all staff. A third detainee declared during the risk assessment that he had a history of self-harm and had attempted suicide. This was corroborated by information on NSPIS. The detainee was sensitively searched. He was being taken straight to court and the information was communicated to the escorting officers and recorded on the prisoner escort record (PER).

4.34 At Kennington, one detainee was placed on constant watch due to the serious nature of the alleged offence. The officer remained outside the closed cell door and observed the detainee through the observation hatch, which was not particularly effective and hindered any interaction.

4.35 None of the custody suites had life signs monitoring systems, but they were equipped with closed-circuit television in some cells. There did not appear to be an over-reliance on this to monitor detainees, which was good as monitoring CCTV required more than one officer so there were periods when no one was available to pick up any issues from the CCTV.

Expectation

4.36 Custody staff have the skills and competencies to deal with detainees at risk of harm to others.

Findings

4.37 No cells were shared and custody staff were vigilant to detainees' risk of harm to others. The risk assessment, the detainees' presentation and information held on NSPIS, where applicable, informed the overall assessment of risk to others.

4.38 At Brixton, the limited holding facilities meant that detainees were often held in the wire meshed exercise area. Where a detainee was agitated, he was often kept in this area until he calmed down. We observed one detainee held in this way as he presented a risk to others. Once calm, officers were able to complete the risk assessment, but also highlight the previous aggressive behaviour towards the arresting officer.

4.39 Detainees were strip searched if they were arrested for drug-related offences and if there was some suspicion that they were concealing a weapon. Custody sergeants said that there was no central record of when strip searches were conducted, but that they were recorded on individual detainee records.

4.40 We observed a busy evening at both Kennington and Brixton. At Kennington, detainees were well managed despite the number of people in the waiting area and the day custody officer did not go off duty until the detainee he was booking in had been dealt with. However, detainees being booked in were not given privacy as solicitors, bail returns and officers waited in the

holding area at the same time. At Brixton, new detainees were kept waiting in the outside area for at least 45 minutes, but this meant the detainee at the desk was not hurried and the risk assessment could be thoroughly completed.

4.41 The number of people in the custody areas at busy times was concerning and increased the potential for an incident to occur while a range of staff and visitors was in the small holding areas at Kennington and Brixton.

Expectation

4.42 All cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to promptly.

Findings

4.43 All cells had working call bells. These were audible, particularly during busy times, and the cell in question was indicated to staff by a red light. We saw DDOs responding promptly at Brixton, but the call bells were little used during our inspection of Streatham and Kennington. In our survey, 21% of detainees, against a comparator[2] of 22%, said staff had explained how and why to use the cell bell, but some we spoke to said they had not been told that they should use the cell bell when they needed something, such as toilet paper or to use the wash basin.

Expectation

4.44 All areas of the custody suite that are used by detainees are clean, safe and in a good state of repair.

Findings

4.45 Custody suites were generally bright and clean. Contract cleaners attended every day and used suitable cleaning materials that were locked away when not in use. Public areas were clean and appropriate information posters were displayed.

4.46 There was no force-wide policy to address the problem of graffiti. Each suite had a graffiti removal programme and this was well under way on benches, door frames and floors. Much of it had been painted over, but was still visible. Custody sergeants prioritised the removal of names, gang-related inscriptions and offensive language from detention cells. A lot of graffiti had been scratched into the lettering of stencilled information about help with drug problems on cell walls and ceilings. The custody sergeant at Streatham said detainees responsible for graffiti had been prosecuted for criminal damage, but the actual number of cases was unclear.

4.47 Two cells with damaged and potentially unsafe benches had been decommissioned awaiting repairs. Potential ligature points had been removed except for a ceiling vent and a toilet bowl support at Kennington. The cell concerned was taken out of use when we highlighted this to the custody sergeant.

[2] The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments.

4.48 Detainees we interviewed thought the cleanliness and lighting of the accommodation was reasonable, but complained about the poor ventilation in the cells. They said lights were dimmed at night. Survey results were broadly in line with the comparator.

Expectation

4.49 Detainees are provided with a mattress, pillow and clean blankets.

Findings

4.50 Detainees in all custody suites were provided with a mattress and pillow covered in tear-proof and waterproof material. These were cleaned with anti-bacterial products by contract cleaners only once a day rather than when a cell was vacated. Mattresses and pillows were given a specialised clean following spillages or contamination with bodily fluids.

4.51 Each detainee was given a fresh clean blanket and DDOs checked for any tears before handing them out. Staff said detainees could have as many blankets as they needed within reason. Used blankets were taken for cleaning once a week and each custody suite had adequate supplies of clean blankets.

Expectation

4.52 Hygiene packs for women are routinely provided.

Findings

4.53 Female detainees were not routinely asked if they required sanitary products on reception, but were told they could speak to a female member of staff. Each custody unit had a range of tampons and sanitary towels. Notices in English only advised female detainees of their availability.

Expectation

4.54 A no smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

Findings

4.55 Smoking was not allowed in any of the custody suites. A custody sergeant at Kennington said that some staff allowed detainees to smoke in the outside caged areas, but this was against policy. Nicotine replacement was not routinely offered and detainees were not told it was available, although anyone who complained that they were suffering withdrawal was offered an interview with the FME who could prescribe a substitute. Custody officers in all suites said it was rarely an issue and that detainees accepted they would not be able to smoke.

Expectation

4.56 Detainees are offered sufficient refreshments at recognised mealtimes and other times that take into account when the detainee last had a meal.

Findings

4.57 All custody suites provided food in insulated containers for detainees from the station canteen when it was open and microwave meals including vegetarian and halal options were available at other times. Meals were offered consistently and at appropriate times. However, detainees were not routinely asked on reception when they had last eaten and custody records indicated that detainees who arrived late in the evening were not offered meals. Staff said detainees who were hungry on arrival would request something to eat when asked about dietary requirements.

4.58 Experienced detention staff had been trained in food handling and hygiene, but newer staff were awaiting training.

Expectation

4.59 Detainees are able to use a toilet in privacy and toilet paper and hand washing facilities are provided.

Findings

4.60 All cells and detention rooms had toilets, although their age and condition varied. The newer toilets were stainless steel. Toilet paper was provided only on request. The toilet area was obscured for privacy on CCTV, as were observation mirrors. No cells or detention rooms had hand washing facilities so detainees had to ask to be let out to wash their hands after using the toilet.

Expectation

4.61 Detainees whose clothing is seized are provided with suitable alternative clothing.

Findings

4.62 Each custody suite had stocks of paper suits, tracksuit bottoms, T-shirts and plimsolls. Stocks at Brixton were low and contained no plimsolls in larger sizes. Streatham also had stocks of long sleeve sweatshirts, but Brixton only had a few and Kennington had none. Detainees could have clothing brought in and this was stored in their property, but those we saw were still wearing the paper suits or tracksuits issued to them. A local homeless charity occasionally supplied Kennington with clothing for released detainees without suitable clothing of their own.

Expectation

4.63 Changes of clothing, especially underwear, are facilitated.

Findings

4.64 All custody suites had a stock of clothing (see paragraph 4.62), but none of these contained underwear.

Expectation

4.65 Detainees are offered the opportunity to have a shower.

Findings

4.66 All custody suites had a full range of toiletries available, but only rolls of absorbent paper instead of towels. In our survey, only 8% of detainees said they had been offered a shower.

4.67 Brixton had only one shower in the men's area, although staff said they would close the area down to allow privacy if a female detainee wanted to use it. The shower was clean and modern and potential ligature points were fully sealed. Custody records indicated that detainees washed rather than used the shower.

4.68 Kennington had one shower in the men's corridor and one in the women's corridor. They had stainless steel anti-ligature fittings, but the vent on one shower had not been adequately sealed to remove a ligature point. Staff said showers were offered in the evenings and mornings, but there was often no time for detainees to shower in the mornings before being taken to court. Custody records of detainees who stayed overnight showed that some showers were offered and taken.

4.69 Streatham had no shower and just one washbasin. Custody records showed that detainees were given the opportunity to use the basin to wash.

Expectation

4.70 Detainees have access to a period of outdoor exercise.

Findings

4.71 The only place detainees could exercise outdoors was the caged area at the entrance to each custody suite. Custody records and interviews with detainees showed that these were not used systematically. Staff at Brixton and Streatham said they let detainees out for fresh air if they were not busy with other duties and we saw two detainees at Brixton using the caged area. At Kennington, two detainees who had been held overnight and were expected to be held longer were given regular breaks in the caged area. However, the custody record of another detainee held at Kennington for three days indicated that he had not been offered any exercise or fresh air. In our survey, only 4% of detainees said they had been offered outdoor exercise.

Expectation

4.72 Those held in custody are provided with suitable reading material.

Findings

4.73 Each custody suite contained some reading material, but little or none in languages other than English. Brixton had only magazines donated by staff and independent visitors, Kennington had a box of books and magazines donated by independent visitors and Streatham had a box

of books, all in English, provided by the local library. Records showed that one detainee at Brixton and one at Kennington had been given a newspaper.

4.74 Each custody suite had Bibles and Korans (in English and Arabic) for detainees to use on request. Brixton also had some Bibles in Portuguese to cater for the substantial local Portuguese-speaking community.

Expectation

4.75 Visits are allowed, especially for those held more than 24 hours.

Findings

4.76 Detainees were not offered social visits and none of the custody suites had any facilities for them. A custody officer at Kennington said the only exception to this was that on occasion a detainee was allowed to meet a friend or family member briefly for the handover of clothing.

Recommendations

4.77 Fire training should be given to all custody staff and fire evacuation drills practised regularly. A notice setting out the actions to take in the event of a fire or evacuation should be posted in custody suites.

4.78 Adapted cells should be available for use by detainees with a disability.

4.79 Detainees should be offered appropriate privacy when being booked in.

4.80 The health and safety of the holding areas across the custody suites should be reviewed to ensure that the safety of detainees and visitors is maintained at all times and particularly during peak periods.

4.81 All detainees should be informed of the religious materials available at the custody suites.

4.82 The names and offences of detainees should be removed from outside cells at Brixton and Kennington.

4.83 The use of cell bells should routinely be explained to detainees.

4.84 A force-wide custody policy to address graffiti should be developed and graffiti should be properly removed from all cells.

4.85 All potential ligature points should be removed from areas where detainees are not closely supervised.

4.86 Female detainees should routinely be told that hygiene packs are available and how they can be accessed.

4.87 Detainees booked in after the evening meal has been served should be offered something to eat.

4.88 Mattresses and pillows should be cleaned between uses and those in a poor state of repair should be replaced.

4.89 The no smoking policy should be consistently enforced.

4.90 On an individually assessed basis, nicotine replacement should be available to smokers.

4.91 All detainees should have access to hand washing facilities.

4.92 Detainees kept overnight should be given clean underwear.

4.93 Detainees should be offered a shower, particularly if they are held for 24 hours.

4.94 Towels should be provided to detainees who want to take a shower.

4.95 Toilet paper should be provided in cells.

4.96 Every custody suite should hold sufficient stocks of clothing suitable for use on release in all weathers.

4.97 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air.

4.98 A range of age-appropriate reading material, including some in relevant languages other than English, should be provided and detainees told that this is available.

4.99 Visits should be allowed for those detained more than 24 hours and for young people.

Housekeeping points

4.100 Detainees should not be referred to by their cell number.

4.101 Detainees should be allowed to change into replacement clothing brought in for them.

5. Individual rights

5.1 Detainees could have someone informed of their whereabouts and were given access to legal representation, appropriate adults and interpreting services as necessary. The interpreting service at Streatham was more limited than at Brixton and Kennington. Access to solicitors and appropriate adults was offered and supplied, but telephone calls to them could not be made in private. The appropriate adult service was restricted in all three custody suites. The taking storing and submission of DNA and forensic samples needed urgent attention. PACE codes were largely adhered to during interviews, but there were concerns about vulnerable adults' access to an appropriate adult. Record-keeping was varied, with some good and some poor. The reasons for handcuffing detainees in a secure area were not properly recorded. Detainees were not given information about making complaints and this was the same system for making racist complaints.

Expectation

5.2 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts.

Findings

5.3 Detainees were asked as part of the initial assessment if they wanted someone informed of their whereabouts. This information was also given in writing and was available in a range of languages. They were asked who they wanted informed and could make the call themselves if preferred. Several attempts were made if the person concerned was unavailable, but calls were made in a public area. Exceptionally, detainees were denied use of the telephone on the basis of a risk assessment.

Expectation

5.4 Detainees who have difficulty communicating are provided for.

Findings

5.5 Detainees being booked in were asked about reading and writing skills, but were not necessarily then offered support through the booking in process. One detainee at Brixton said he was dyslexic and that his reading was poor, but was still asked by the custody sergeant to read a document without any help. He was unable to do so and consequently signed the form without knowing what it said.

5.6 Custody sergeants checked detainees' understanding of English and whether they had any other communication difficulties. The rights and entitlements leaflet was available on the intranet in 45 languages and this was shown to detainees as required. Custody staff had a list of interpreters they could contact when booking in detainees with little or no English. Interpreters were also used to help detainees during interviews. Sign language interpreters were also available. No hearing loops were available at any of the custody suites.

5.7 Brixton and Kennington had access to a professional telephone interpreting service, but Streatham did not. Use was regularly made of interpreters, but primarily for PACE interviews. Accessing suitable interpreters was variable during unsocial hours. There was one occasion where an interpreter was used, but this was not recorded.

Expectation

5.8 Police custody is not used as a place of safety for children and young people under section 46 of the Children Act 1989.

Findings

5.9 The custody suites were not used as a place of safety for children and young people under section 46 of the Children Act.

Expectation

5.10 Persons detained who have dependency obligations are catered for.

Findings

5.11 Detainees were regularly asked about any dependency obligations. They were allowed to make a telephone call to arrange for dependents to be cared for and several had been given additional telephone calls to make arrangements. Custody records provided further examples where dependency obligations were catered for.

5.12 When no other arrangements could be made, social services were contacted, but were often unavailable. If custody staff could not resolve the dependency obligations through family or friends, they sent a car to make a welfare visit or made arrangements to bail an individual to return to the police station at a more suitable time. Arrangements were generally made in a public area.

Expectation

5.13 All detainees are able to consult with legal representatives in private for free. Those under the age of 18, vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present.

Findings

5.14 A duty solicitor scheme provided free legal and specialist immigration advice for detainees. Legal advisers attended within a reasonable timescale and detainees could meet them in separate consultation/interview rooms when required.

5.15 Kennington had too few interview rooms. Chairs were not bolted down in any of the interview rooms and could have been used as weapons. At Brixton and Streatham, the sound proofing in the interview rooms was of poor quality. One interview room next to the custody entrance corridor was adequately sound proofed, but a gap of over an inch at the bottom of the door allowed all the noise from outside to enter the room.

5.16 An appropriate adult was sought from family and friends where appropriate for vulnerable adults, those under the age of 17 and those with learning difficulties. We remained concerned that 17-year-olds were excluded from the PACE protections for juveniles. When this was unsuitable or unavailable, the appropriate adult scheme (TAAS) was available.

5.17 The custody record of one adult with learning difficulties showed that they were not assessed as a vulnerable adult despite a range of information to the contrary in the risk assessment. Custody records and our observations indicated that vulnerable adults, those with learning disabilities and young people were occasionally interviewed without an appropriate adult in attendance.

5.18 The appropriate adult service was available 24 hours a day for all, but for juveniles was coordinated through the youth offending team between 9am and 5pm. TAAS always requested a solicitor to attend 30 minutes before they arrived and would attend only for PACE interviews.

5.19 Solicitors said it was difficult to get through to the stations by telephone. Delays in receiving disclosure information were also reported at Kennington. There was evidence that detainees were sometimes advised that accessing a solicitor would cause further delays and they were therefore discouraged from doing so. Solicitors waiting in reception at Kennington were not fast-tracked to see their client, which also resulted in delays.

Expectation

5.20 Robust mechanisms for ensuring continuity of evidence are in place.

Findings

5.21 The DNA/forensic freezer at Brixton and the regulation of forensic samples and exhibits were better than any we have seen on previous inspections within the MPS. The local detective inspector had a thorough regime operating for the storage, processing and destruction of DNA and forensic samples.

5.22 The arrangement at Kennington was a stark contrast. There were two freezers and one fridge. The fridge was filled with exhibits that fell out when the door was opened. Not all exhibits were therefore examined, but a number were post-mortem exhibits or samples. There were 24 PACE DNA samples that had not been submitted to the national DNA database and it was not possible to establish why not. A number were labelled as having been taken for very serious offences, including attempted murder and rape. Some were dated 2004 and 2005 and their non-submission had the potential to lead to cold cases not being solved. The storage of forensic exhibits breached the instructions on the fridge and freezer doors and was not managed effectively or efficiently. Samples at Streatham were not kept in the fridge there for more than a few hours. Samples taken from detainees were forwarded the same day.

5.23 A legal representative reported samples such as nail clippings sometimes being taken in an uncontrolled environment and there was a lack of forensic testing kits at Kennington. This caused delays while kits were sought from other police stations. Another issue raised by a solicitor was that officers sometimes took intimate samples as a matter of urgency, therefore denying them the opportunity to advise their clients about consent.

Expectation

5.24 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit, unless in circumstances provided for under PACE.

Findings

5.25 Custody records and our observations indicated that this did not happen regularly. Legal representatives were occasionally asked to attend when a detainee was being interviewed even though they were unfit for interview. This sometimes occurred during a changeover in shift, when a review that should have taken place was not held or the mental or physical state of a detainee had deteriorated.

Expectation

5.26 Detainees are not deliberately denied any services they need during the interview process and are granted a period of 8 hours continuous break from interviewing in a 24 hour period.

Findings

5.27 Interviewing officers at all stations did not carry out interviews for overly long periods and detainees were given breaks. Custody records showed that detainees were given eight hours rest during 24-hour periods. Legal advisers confirmed that appropriate rest periods were given. Custody records showed that some detainees brought into custody at night were dealt with in a reasonable time. When appropriate, they were interviewed and charged during the night, minimising delays in their case being dealt with. Record-keeping was poor in many aspects and some custody records at Kennington did not show the time detainees were returned to their cells following interview in the body of the custody record.

Expectation

5.28 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

5.29 Staff said they would not handcuff detainees unnecessarily in the secure custody area and only if they posed a risk to themselves or others. We observed custody sergeants assessing the risks posed by detainees before the booking in process and handcuffs were removed immediately for all detainees we saw booked in. Two custody records indicated that detainees had been handcuffed in the secure area at Kennington with no reasons recorded. The custody sergeant we spoke to suggested that one instance could be because the detainee was waiting to have forensic samples taken from his hands, but could not account for the second instance. In another case, a juvenile had been forcibly restrained at Streatham to remove his training shoes for evidential purposes. The record showed that he was then placed in handcuffs and in a detention cell. There was no record of when the handcuffs had been removed.

Expectation

5.30 Detainees who have been charged appear at court promptly either in person or via video link.

Findings

5.31 Staff at all three custody suites were required to have detainees booked into the local courts by 1pm on weekdays and noon on Saturdays. This appeared restrictive and resulted in detainees being kept in custody longer than necessary, particularly if they had been arrested on a Friday. Custody sergeants said they would bail detainees if they could, but this was not possible for those wanted on warrant or who had breached bail. One detainee at Streatham had been sent to court and arrived at 1.40pm, but had been refused by the court and returned to the police station. He had been kept in custody overnight before returning to court the next day as it was not possible to bail him.

5.32 There were no video link facilities. A prototype had been trialled at Kennington and was due to be installed the week after the inspection. It was being put in one of the interview rooms, which would result in a conflict of use for that room, with staff saying detainees requiring interview would take precedence to expedite their cases.

Expectation

5.33 Detainees are told how they can make a complaint about their care and treatment and are enabled to do so if they wish.

Findings

5.34 The acting borough commander felt that the low number of complaints reflected improved services. However, we found evidence of detainees repeatedly making requests to have their complaint formally recorded while in custody, only to be told that they could make complaints at the front desk when they left custody.

5.35 No information about making a complaint was displayed in any suite and staff said they would offer information only if asked or if someone actually wanted to complain. Detainees we spoke said they had not been told how to make complaints. At Kennington and Streatham, staff said they would refer detainees to the front desk as they left to report the matter to the duty inspector. Neither station had any information displayed or readily available at the front desk. At Brixton, the custody sergeant said he would try to deal with simple complaints, such as about lack of food or clothing, and would otherwise refer detainees to the front desk for information.

5.36 A detainee in custody at Brixton told staff he wished to make a complaint about the use of excessive force by police officers, during which he said he had sustained injuries. Staff noted in his custody record that he should go to the front desk on his release to make the complaint, but would not photograph the injuries as they had not been recorded by the forensic medical examiner. The detainee's solicitor was given the same information when trying to pursue the complaint.

Expectation

5.37 There is an effective system in place for reporting and dealing with racist incidents.

Findings

5.38 Racist complaints were dealt with in the same way as other complaints.

Expectation

5.39 All detainees can consult a copy of the PACE Code of Practice C.

Findings

5.40 All three custody suites had copies of the current PACE code of practice, which were offered to detainees during the booking in process. Detainees were given this information in writing and verbally and it was available in several languages. Detainees confirmed that they had been offered the information and some had asked for, and been given, the code of practice.

Expectation

5.41 Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

5.42 Solicitors were given copies of custody records when they arrived to see their clients. There was evidence that copies had been requested and supplied after the detainee had left custody. We also observed copies being given on request, although one custody sergeant at Brixton said he would not give copies out until a detainee had been charged and then only as a last resort.

Expectation

5.43 Pre-release risk management planning for vulnerable detainees is conducted to ensure they are released safely.

Findings

5.44 None of the custody suites had formal policies on pre-release risk management. We observed staff offering to drive young and vulnerable detainees home after they had been dealt with and ensuring that other detainees had the means to get home and knew how to get there.

5.45 Custody records confirmed that young people and vulnerable adults were released into the care of appropriate persons or offered lifts home. Staff said they used common sense to determine what support was required on release. They also said some support was available from the drugs workers and the mental health team, but this was not done under any formal arrangement.

Recommendations

5.46 Access to a professional telephone interpreting service should be set up at Streatham.

5.47 Detainees should be offered appropriate privacy when making or receiving a telephone call at the booking in desk.

5.48 Detainees who have difficulties reading and writing should be supported to read documents before being required to sign them.

5.49 Interview and consultation rooms should be fully soundproofed to protect the integrity of the interview.

5.50 Furniture in interview rooms that could be used as weapons should be bolted to the floor.

5.51 Custody staff should not try to dissuade detainees from seeking legal advice.

5.52 Detainees aged 17 years should be provided with an appropriate adult.

5.53 Forensic samples should be taken in a controlled environment.

5.54 Access to legal advice about consent in the taking of intimate samples should be available for detainees.

5.55 The ongoing issues within the Metropolitan Police Service surrounding the taking, storing, submission and security of forensic and DNA samples should be addressed as a matter of urgency in consultation with the Forensic Science Regulator.

5.56 The Metropolitan Police Service should provide boroughs with glass-fronted and strong fridges and freezers so that supervisors can easily identify problems with storage capacity, frosting and defrosting.

5.57 All PACE DNA samples should be submitted to the national DNA database or destroyed as soon as practicable. This should be closely monitored at a senior management team level.

5.58 The Metropolitan Police Service should initiate a pan-borough search of all its fridges and freezers to ensure that all DNA samples that have been lawfully taken are submitted to the national DNA database as soon as practicable. An audit trail of this procedure should be maintained and retained for future reference.

5.59 A stock of forensic testing kits should be maintained at all three sites.

5.60 Custody records should accurately reflect the times, details of and reasons for all occurrences for individual detainees and in particular where handcuffs are applied to detainees in the suites.

5.61 The court service and the borough commander should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links.

5.62 An alternative interview room should be provided at Kennington to allow full use of the new video link facility.

5.63 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on.

5.64 Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated.

5.65 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites.

5.66 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on.

5.67 The pre-release risk management policy should be implemented consistently, particularly for vulnerable and young people, with actions taken recorded on NSPIS. Custody staff should receive training in this process.

6. Healthcare

6.1 Health services were provided by forensic medical examiners (FMEs) working to a contract with the Police Authority (with the intention that the services were provided for the Commissioner within the Metropolitan Police Forensic Medical Service). There did not appear to be a lead FME and practitioners appeared to work independently. Police custody staff were varied in their opinion of the FME service. Police custody staff were mindful of the need to ensure that health needs were monitored and addressed while in custody. Mental health and drug support services were well structured, but had no regular presence in any of the custody suites.

Expectation

6.2 Detainees are treated by health care professionals and drug treatment workers in a professional and caring manner that respects their decency, privacy and dignity and is sensitive to their situation and diverse needs, including language needs.

Findings

6.3 Face-to-face contact with health professionals and drug workers was extremely limited as neither group attended the custody suites regularly. We met two FMEs, but neither was with detainees at the time. Both presented as professional individuals with a good awareness of the clinical and diverse needs of detainees.

Expectation

6.4 Clinical governance arrangements include the management, training and supervision and accountability of staff

Finding

6.5 Clinical governance arrangements for the FMEs were not clear. A new contract between individual FMEs and the Police Authority (with the intention that the services were provided for the Commissioner within the Metropolitan Police Forensic Medical Service) had been introduced a few months previously, but did not explicitly state who would carry out appraisals or ensure that FMEs undertook relevant professional development. However, we were told that a medical director was soon to be appointed and would take on this role among other duties. There was no monitoring at a local level of the contracts, although we understood this was carried out across the Metropolitan Force. None of the FMEs we spoke to had regular appraisals or supervision, but said the Forensic Medical Service (FMS) had arranged regular professional updating. One said he had a professional development plan and had to provide evidence of ongoing professional development to the FMS. Approximately 200 doctors, including female doctors, had been recruited to provide a pan-London service to the MPA, but the MPA was unable to provide us with evidence of professional registration, qualifications of FMEs and training requirements without a formal request in writing. Some of the doctors were general practitioners or psychiatrists. They told us that very few were Section 12 approved under the Mental Health Act 2007.

Expectation

6.6 Patients are treated by health care staff who receive on-going training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular health care needs of detainees in police custody.

Findings

6.7 Some of the doctors working in the borough were solely FMEs. They said they attended lectures and other professional development to maintain their professional registration. Financial incentives were offered to FMEs completing the Diploma in Forensic Medical Sciences. As well as FMS doctors, agency doctors were brought in to cover shifts. Custody staff did not know the qualifications of doctors or whether they were general practitioners or psychiatrists. There did not appear to be any overarching quality assurance of doctors attending detainees and there was anecdotal evidence of irregularities in the application process for some doctors.

Expectation

6.8 Clinical examinations are conducted out of the sight and preferably out of the hearing of police officers. Treatment rooms provide conditions that maintain decency, privacy and dignity. Infection control facilities are implemented. There is at least one room that is capable of being used for the taking of forensic samples and it is clean.

Findings

6.9 All the clinical rooms were satisfactory, although the one at Streatham was particularly small. None had privacy screening around the couch, which compromised decency and dignity, especially as two of the rooms (at Brixton and Kennington) opened directly on to the main booking in area. The couch at Streatham was held together by sticky tape, which posed an infection risk. All the couches had paper roll. All the rooms lacked even basic equipment, such as a glucometer and sphygmomanometer. Fridge temperatures were not taken or recorded. The sharps boxes were not dated, timed or signed on opening. There were yellow clinical waste bags in each of the rooms, which had been emptied before our arrival, and clinical waste bags were used for non-clinical waste.

Expectation

6.10 All medications on site are stored safely and securely, and disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

Findings

6.11 Guidance for the security, administration and disposal of drugs and medicines in custody had recently been introduced to ensure that a safe regime for the administration of medication to those in custody was maintained. There was a stock list in each room and new drugs cupboards in all the rooms. The drug cupboard in Kennington was poorly sited. All the cupboards were neat and tidy, with no medications out of date. There was no adrenaline stock

despite it being on the stock list and no anaphylaxis kit, although we understood that this was due to a supply problem. There were no drug reference books. The ordering and storage of medications was the responsibility of a custody sergeant or inspector in each suite. Each had introduced a book for recording medications used to make reordering of stock easier, but it appeared that the FMEs were not using the new system. During a night visit, we found that one of the FMEs had left their medical bag unsupervised in the open FME room. We also found two separate Henley bags containing diazepam and paracetamol for a named patient left behind the custody desk, despite the fact that the detainee concerned had been released.

Expectation

6.12 All equipment (including resuscitation kit) is regularly checked and maintained and all staff (health care and custody staff) understand how to access and use it effectively

Findings

6.13 Each suite had a defibrillator located close to the custody desk. All were checked daily (including the expiry dates of the pads) as part of the handover between custody sergeants. At Streatham, there were spare pads available and a rescu-vac ready for use. Staff said officers received annual update training.

Expectation

6.14 Detainees are asked if they wish to see a health care professional and are able to request to see one at any time, for both physical and mental health needs.

Findings

6.15 We were concerned to note that FMEs who provided cover to the custody suites in Lambeth were also covering suites in other boroughs. Custody staff at all three suites spoke of their significant frustration at having to wait a long time for an FME and their concern that not all the doctors on the rota were knowledgeable about working in a custody suite.

6.16 On one occasion, an FME had failed to respond to calls for over five hours and the next doctor on duty therefore had a backlog of at least eight patients to see at one custody suite alone. On another, an FME requested to attend Brixton at 6.40pm was in another suite seeing four detainees and did not arrive at Brixton until 9.40pm. He was then due to be at Battersea custody suite at 11pm to examine four detainees and three injured officers. In our survey, one respondent who had been held at Brixton commented, 'I never saw a doctor for hours and hours and came into the jail sick.'

6.17 FMEs' normal shifts were six hours, although double shifts of 12 hours were permitted. There were 19 FMEs on the current rota, which covered a 39-day period. During this period, an FME had worked a 12-hour shift on 34 days, with one working a total of 14 double shifts. Having just one FME to cover what was arguably the busiest time in the custody suites was questionable. No FME was allowed to work longer than 12 hours, but they were paid only for the work they did and some had other jobs, so it was possible that some worked longer hours. FMEs on duty covered clusters of police cells, usually involving three custody suites, but it was not uncommon for one FME to cover six suites, particularly at night.

Expectation

6.18 Detainees continue to receive prescribed medication for any clinical condition, and to receive medication to provide relief for drug and alcohol withdrawal symptoms if needed.

Findings

6.19 Custody staff said detainees disclosing regular prescribed medication needs were seen by the FME and officers went to the detainee's home to collect medication whenever possible. Once verified by the FME, the detainee was allowed to continue their medication. Those prescribed medication by the FME received it from custody staff. Although we were told that administration of medicines would be recorded onto NSPIS (the police custody software application), we could not confirm this. One detainee had been seen by a FME and prescribed anti-inflammatory medications for an ongoing condition. The medication had been prescribed six-hourly and the detainee had spent at least 36 hours in custody, but it was unclear whether he had received more than one dose of the medication in that time.

6.20 Detainees taking substance misuse medicines could continue to do so once the FME had verified with either their GP or local drug intervention programme (DIP) team. Again, custody staff collected the medication, which was always administered by the FME. One FME confirmed that they personally would administer Methadone if the detainee brought it with them, it was verified with the detainee's GP or DIP team and was correctly labelled. They said they would also provide immediate symptomatic relief if clinically indicated.

6.21 The FMEs we met carried a wide range of commonly used medicines.

Expectation

6.22 Each detainee seen by health care staff has a clinical record containing an up-to-date assessment and any care plan conforms to professional guidance from the regulatory bodies. Ethnicity of the detainee is also recorded.

Findings

6.23 The FME contract made clear that all clinical records made by the FME remained subject to their physical control and to the normal regulations and statutory provisions governing medical records, as well as the related principles of good medical practice in record-keeping promulgated by the General Medical Council. FMEs were responsible for their retention and secure storage. The FMEs we spoke to said they kept their own clinical records, which they stored at home.

6.24 Not all the doctors were familiar with the practices of working in a custody suite and not all had been trained to use, or had access to, NSPIS. Custody staff therefore had to print off a hard copy of the custody record for the agency doctor, who, at the end of his consultation, dictated his entry on to NSPIS to one of the custody staff who typed it into the system. This was a cause of great concern to custody staff and a waste of time for all concerned. The doctors also used the book 83 to record their clinical findings. Some FMEs' handwriting was indecipherable. Some clinical records on NSPIS also did not provide a full contemporaneous account of clinical

consultations. Some of the consultations appeared only to be recorded in the book 83 and not on NSPIS. This was poor practice.

6.25 The ethnicity of the detainee was entered on the main custody record during the booking in process.

Expectation

6.26 Any contact with a doctor or other health care professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.

Findings

6.27 FMEs entered all consultations and dispensing of medication onto NSPIS and/or book 83 depending on the FMEs ability to use the computer system. Using two systems risked discrepancies in clinical records. At Brixton, some custody staff felt that some FMEs did not always provide a comprehensive debrief to staff managing detainees. One senior officer said they were sometimes asked to administer Class A drugs, which they rightly refused to do.

Expectation

6.28 Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prison drugs workers as appropriate.

Findings

6.29 Crime Reduction Initiatives (CRI) provided drug workers to all three custody suites. They were present at Brixton 24 hours a day and provided cover at the other two suites from 7am to 10pm. Despite the level of cover, the workers saw only adults who used Class A drugs, crack or heroin, and those with 'trigger offences' and those who had a positive drugs test. They were not well integrated into the custody suite team and said they had little to do with the FMEs, but would make contact with local mental health services if the detainee told them they were known to services. We were unable to establish how effectively they linked into DIP teams in the community.

Expectation

6.30 A liaison and/or diversion scheme enables detainees with mental health problems to be identified and diverted into appropriate mental health services, or referred on to prison health services

Findings

6.31 There was no liaison or diversion scheme, although local mental health services were good and it was normally possible to transfer a detainee with mental health problems expeditiously to NHS in-patient facilities. Custody staff did not express concern at the length of time such transfers took. There was no formal procedure for referring detainees with mental health

problems to prison health services. A recurring theme in ICV reports concerned vulnerable adults with a mental health issue and the unsatisfactory links with borough-based mental health crisis teams.

Expectation

6.32 Police custody is not used as a place of safety for section 136 assessments except where the detainee needs to be controlled for his or her own safety or the safety of others.

Findings

6.33 Lambeth BCU had good arrangements with the South London and Maudsley Mental Health Trust (SLAM) so that detainees arrested using Section 136 of the Mental Health Act were taken to the Section 136 suite at Lambeth Hospital. Between December 2008 and June 2009, 121 detainees from Lambeth police stations had been referred to the 136 suite.

6.34 The Trust had a comprehensive joint policy with the police for the use of the suite and there were quarterly liaison meetings between all the parties involved. An inspector based within Lambeth BCU took the lead in liaison with the Trust. SLAM had recently provided some mental health training to police in Lambeth BCU, including how the joint policy could be used and basic mental health awareness.

Recommendations

6.35 The Forensic Medical Service should review the forensic medical examiner on call system to ensure that response times are agreed and appropriate. The system should be audited regularly to ensure the medical needs of detainees are met within acceptable limits.

6.36 Custody staff should never be asked to administer Class A medicines.

6.37 There should be clear lines of accountability and an appraisal system for forensic medical examiners and the contract monitoring should be shared with custody staff.

6.38 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development.

6.39 Healthcare professionals should have access to basic clinical equipment, such as a glucometer, sphygmomanometer and ophthalmoscope, in the clinical room.

6.40 All custody staff and healthcare professionals should have the newly introduced guidelines for the security, management, administration and disposal of drugs and medicines in custody reiterated to them and these should be followed. There should be audits of compliance.

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

6.42 The Forensic Medical Service should ensure that all its doctors are conversant with, and able to use, the NSPIS system before taking up appointment.

6.43 There should be regular and formal liaison between healthcare professionals and substance misuse workers.

6.44 Services should be provided to meet the needs of detainees who present with alcohol abuse issues.

6.45 There should be a liaison/diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services.

Housekeeping points

6.46 Privacy screens should be provided in forensic medical examiner rooms.

6.47 The medical couch at Streatham should be replaced.

6.48 Clinical waste bags should not be used for normal waste.

6.49 The drug cupboard at Kennington should be resited.

6.50 Healthcare professionals should have access to up-to-date drug reference books.

7. Summary of recommendations

Strategy

To the Metropolitan Police Service

7.1 To ensure the implementation of corporate policies and the maintenance of corporate standards, the Metropolitan Police Service should consider putting the management of all custody suites under one operational command unit. (3.18)

7.2 Police officers and staff should access the 'lessons learned' circular from the Independent Police Complaints Commission. (3.19)

7.3 The Metropolitan Police Service should engage with relevant partners to ensure that there is an effective appropriate adult scheme in operation for both vulnerable adults and juveniles. (3.20)

7.4 The old closed-circuit television system at Brixton should be replaced by an up-to-date digital system. (3.21)

7.5 The quality control systems in place to govern the storage and tracking of closed-circuit television recordings should be reviewed, with new robust systems replacing the current flawed ones. (3.22)

To the Metropolitan Police Authority

7.6 The Metropolitan Police Authority should allocate one authority member as lead for custody. (3.23)

Treatment and conditions

7.7 Fire training should be given to all custody staff and fire evacuation drills practised regularly. A notice setting out the actions to take in the event of a fire or evacuation should be posted in custody suites. (4.77)

7.8 Adapted cells should be available for use by detainees with a disability. (4.78)

7.9 Detainees should be offered appropriate privacy when being booked in. (4.79)

7.10 The health and safety of the holding areas across the custody suites should be reviewed to ensure that the safety of detainees and visitors is maintained at all times and particularly during peak periods. (4.80)

7.11 All detainees should be informed of the religious materials available at the custody suites. (4.81)

7.12 The names and offences of detainees should be removed from outside cells at Brixton and Kennington. (4.82)

7.13 The use of cell bells should routinely be explained to detainees. (4.83)

7.14 A force-wide custody policy to address graffiti should be developed and graffiti should be properly removed from all cells. (4.84)

7.15 All potential ligature points should be removed from areas where detainees are not closely supervised. (4.85)

7.16 Female detainees should routinely be told that hygiene packs are available and how they can be accessed. (4.86)

7.17 Detainees booked in after the evening meal has been served should be offered something to eat. (4.87)

7.18 Mattresses and pillows should be cleaned between uses and those in a poor state of repair should be replaced. (4.88)

7.19 The no smoking policy should be consistently enforced. (4.89)

7.20 On an individually assessed basis, nicotine replacement should be available to smokers. (4.90)

7.21 All detainees should have access to hand washing facilities. (4.91)

7.22 Detainees kept overnight should be given clean underwear. (4.92)

7.23 Detainees should be offered a shower, particularly if they are held for 24 hours. (4.93)

7.24 Towels should be provided to detainees who want to take a shower. (4.94)

7.25 Toilet paper should be provided in cells. (4.95)

7.26 Every custody suite should hold sufficient stocks of clothing suitable for use on release in all weathers. (4.96)

7.27 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air. (4.97)

7.28 A range of age-appropriate reading material, including some in relevant languages other than English, should be provided and detainees told that this is available. (4.98)

7.29 Visits should be allowed for those detained more than 24 hours and for young people. (4.99)

Individual rights

7.30 Access to a professional telephone interpreting service should be set up at Streatham. (5.46)

7.31 Detainees should be offered appropriate privacy when making or receiving a telephone call at the booking in desk. (5.47)

7.32 Detainees who have difficulties reading and writing should be supported to read documents before being required to sign them. (5.48)

7.33 Interview and consultation rooms should be fully soundproofed to protect the integrity of the interview. (5.49)

7.34 Furniture in interview rooms that could be used as weapons should be bolted to the floor. (5.50)

7.35 Custody staff should not try to dissuade detainees from seeking legal advice. (5.51)

7.36 Detainees aged 17 years should be provided with an appropriate adult. (5.52)

7.37 Forensic samples should be taken in a controlled environment. (5.53)

7.38 Access to legal advice about consent in the taking of intimate samples should be available for detainees. (5.54)

7.39 The ongoing issues within the Metropolitan Police Service surrounding the taking, storing, submission and security of forensic and DNA samples should be addressed as a matter of urgency in consultation with the Forensic Science Regulator. (5.55)

7.40 The Metropolitan Police Service should provide boroughs with glass-fronted and strong fridges and freezers so that supervisors can easily identify problems with storage capacity, frosting and defrosting. (5.56)

7.41 All PACE DNA samples should be submitted to the national DNA database or destroyed as soon as practicable. This should be closely monitored at a senior management team level. (5.57)

7.42 The Metropolitan Police Service should initiate a pan-borough search of all its fridges and freezers to ensure that all DNA samples that have been lawfully taken are submitted to the national DNA database as soon as practicable. An audit trail of this procedure should be maintained and retained for future reference. (5.58)

7.43 A stock of forensic testing kits should be maintained at all three sites. (5.59)

7.44 Custody records should accurately reflect the times, details of and reasons for all occurrences for individual detainees and in particular where handcuffs are applied to detainees in the suites. (5.60)

7.45 The court service and the borough commander should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links. (5.61)

7.46 An alternative interview room should be provided at Kennington to allow full use of the new video link facility. (5.62)

7.47 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.63)

7.48 Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated. (5.64)

7.49 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites. (5.65)

7.50 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.66)

7.51 The pre-release risk management policy should be implemented consistently, particularly for vulnerable and young people, with actions taken recorded on NSPIS. Custody staff should receive training in this process. (5.67)

Healthcare

7.52 The Forensic Medical Service should review the forensic medical examiner on call system to ensure that response times are agreed and appropriate. The system should be audited regularly to ensure the medical needs of detainees are met within acceptable limits. (6.35)

7.53 Custody staff should never be asked to administer Class A medicines. (6.36)

7.54 There should be clear lines of accountability and an appraisal system for forensic medical examiners and the contract monitoring should be shared with custody staff. (6.37)

7.55 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development. (6.38)

7.56 Healthcare professionals should have access to basic clinical equipment, such as a glucometer, sphygmomanometer and ophthalmoscope, in the clinical room. (6.39)

7.57 All custody staff and healthcare professionals should have the newly introduced guidelines for the security, management, administration and disposal of drugs and medicines in custody reiterated to them and these should be followed. There should be audits of compliance. (6.40)

7.58 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance. (6.41)

7.59 The Forensic Medical Service should ensure that all its doctors are conversant with, and able to use, the NSPIS system before taking up appointment. (6.42)

7.60 There should be regular and formal liaison between healthcare professionals and substance misuse workers. (6.43)

7.61 Services should be provided to meet the needs of detainees who present with alcohol abuse issues. (6.44)

7.62 There should be a liaison/diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services. (6.45)

Housekeeping points

Treatment and conditions

7.63 Detainees should not be referred to by their cell number. (4.100)

7.64 Detainees should be allowed to change into replacement clothing brought in for them. (4.101)

Healthcare

7.65 Privacy screens should be provided in forensic medical examiner rooms. (6.46)

7.66 The medical couch at Streatham should be replaced. (6.47)

7.67 Clinical waste bags should not be used for normal waste. (6.48)

7.68 The drug cupboard at Kennington should be resited. (6.49)

7.69 Healthcare professionals should have access to up-to-date drug reference books. (6.50)

Appendix I : Inspection team

Sara Snell	-	HMIP team leader
Paddy Craig	-	HMIC inspector
Sean Sullivan	-	HMIP inspector
Karen Dillon	-	HMIP inspector
Vinnett Pearcy	-	HMIP inspector
Andrew Rooke	-	HMIP inspector
Anita Saigal	-	HMIP inspector
Catherine Nichols	-	HMIP researcher
Bridget McEvilly	-	HMIP healthcare inspector
Elizabeth Tysoe	-	HMIP healthcare inspector

Appendix II : Custody Record Analysis

Background

As part of the inspection of Lambeth Borough police custody cells, a sample of the custody records of detainees held between 25 May and 1 June 2009 were analysed. Custody records were held electronically on NSPIS. A total sample of 27 records were analysed from across the Lambeth area:

Custody suite	Number of records analysed
Brixton	9
Kennington	9
Streatham	9
TOTAL	27

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

- Seven (26%) of the detainees were female and 20 were male.
- Three people (11%) aged 17 or under were included in the sample.
- Six (22%) detainees were white European and 21 were from a black and minority ethnic background.
- Nine (33%) detainees had been held for more than 12 hours; only one of these detainees had been held for over 24 hours.

Removal of clothing

One detainee had had clothing removed, but there was no record of how or when this happened and no indication of any replacement clothing given.

Young people

- For the two young people aged 15 in our sample, they had appropriate adults requested and present in their interview and while rights were read.
- The 17 year old did not. For four of the cases, appropriate adults had attended and sat in on interviews.

Interpreters

Only one detainee (4%) was recorded as not understanding English. Interpreters were requested and attended. Their rights were given again, translated for the detainee and as a response a solicitor was also requested. The detainee was bailed to return without being interviewed.

Immigration detainees

Only one person in our sample was an immigration detainee. They had left the station within five hours of arriving. He was released, bailed to his home, to report to immigration services.

Services

- It is unclear whether detainees were asked if they wanted someone informed of their arrest as this was not recorded. Only four (15%) detainees had made additional telephone calls and one had declined to make a call. The other 22 made no calls and there was no record of them asking/being declined a call.
- All detainees had been asked if they wanted a solicitor. Eleven (41%) detainees had requested a solicitor and spoken/seen either their solicitor or a duty solicitor.
- No detainees shared a cell in custody.
- Twelve (44%) detainees had seen the FME. The longest wait was nine hours where the FME was called at 11pm and did not arrive until 8.45am. The shortest time to be seen was one minute. However, it was often unclear at what time the FME was called as only the time the detainee was seen was recorded. In some records, the information about the medical examination was not on NSPIS as the FME was not trained to use the system.
- Twelve (44%) detainees had eaten at least one meal in custody. An additional two detainees had been offered but had refused a meal. There were many examples of detainees being released in the morning having been held overnight with no offer of breakfast recorded, as they left for court early being picked up by SERCO around 7am.
- Three detainees had received a 'wash' in Streatham, but no detainees had received a shower. Four detainees had the opportunity for showers in Kennington and Brixton; one detainee at Brixton declined this offer.
- No detainees had received outside exercise.
- No detainees had been provided with reading materials.

Additional points of note

- NSPIS automatically promoted staff to check whether females arriving in custody wanted to speak to a female member of staff in private.
- The foreign nationals rights procedure was conducted with foreign national detainees.
- There were a number of incorrect entries made on custody records that related to other detainees and had to be retrospectively indicated as incorrect.

Appendix III : Summary of detainee questionnaires and interviews

Brixton prison survey methodology

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

Choosing the sample size

The survey was conducted on the 9th June 2009. A list of potential prisoners, who had been through Lambeth police station, was created listing those from Camberwell Magistrates court.

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:

- to 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; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

25 prisoners in total returned the completed questionnaire given to them, after being identified as having been in a police custody suite in Lambeth, within the last month.

Completion of the questionnaire was voluntary. One prisoner could not read or write and so they were interviewed.

Police Custody Survey
Section 1: About You

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

Brixton - 12; Streatham - 11 ; Kennington - 2, Not recorded - 1

Q3 **What type of detainee were you?**

Police detainee	25
Prison lock-out (i.e. you were in custody in a prison before coming here)	1
Immigration detainee	0
I don't know	0

Q4 **How old are you?**

16 years or younger	0	*40-49 years*	5
17-21 years	0	*50-59 years*	2
22-29 years	14	*60 years or older*	0
30-39 years	5		

Q5 **Are you:**

Male	26
Female	0
Transgender/Transexual	0

Q6 **What is your ethnic origin?**

White - British	6
White - Irish	0
White - Other	3
Black or Black British - Caribbean	9
Black or Black British - African	2
Black or Black British - Other	0
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	0
Asian or Asian British - Bangladeshi	1
Asian or Asian British - Other	1
Mixed Race - White and Black Caribbean	2
Mixed Race - White and Black African	0
Mixed Race - White and Asian	0
Mixed Race - Other	0
Chinese	0
Other ethnic group	1

Please specify:

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

Yes	5
No	20

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

None	5
Church of England	7
Catholic	5

Protestant 0
Other Christian denomination 1
Buddhist 0
Hindu 1
Jewish 0
Muslim 7
Sikh 0
Any other religion, please specify 2

Q9 How would you describe your sexual orientation?
Straight / Heterosexual 24
Gay / Lesbian / Homosexual 0
Bisexual 0
Other (please specify): 1

Q10 Do you consider yourself to have a disability?
Yes 4
No 20
Don't know 1

Q11 Have you ever been held in police custody before?
Yes 24
No 2

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?
1 hour or less 2
More than 1 hour, but less than 6 hours 4
More than 6 hours, but less than 12 hours 1
More than 12 hours, but less than 24 hours 9
More than 24 hours, but less than 48 hours (2 days) 7
More than 48 hours (2 days), but less than 72 hours (3 days) 2
72 hours (3 days) or more 1

Q13 Were you given information about your arrest and your entitlements when you arrived there?
Yes 19
No 6
Don't know/Can't remember 0

Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')**?**
Yes 14
No 9
I don't know what this is/I don't remember 3

Q15 If your clothes were taken away, were you offered different clothing to wear?
My clothes were not taken 20
I was offered a tracksuit to wear 2
I was offered an evidence suit to wear 1
I was offered a blanket 1

Q16 **Could you use a toilet when you needed to?**

Yes	24
No	1
Don't Know	1

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

	Yes	*No*
Toilet paper	18	7

Q18 **Did you share a cell at the police station?**

Yes	2
No	24

Q19 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	6	9	9
Ventilation / Air Quality	5	6	11
Temperature	2	9	12
Lighting	9	4	9

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

Yes	17
No	9

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

Yes	5
No	20

Q22 **Were you held overnight?**

Yes	21
No	5

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

Not held overnight	5
Pillow	4
Blanket	13
Nothing	6

Q24 **Were you offered a shower at the police station?**

Yes	2
No	24

Q25 **Were you offered any period of outside exercise whilst there?**

Yes	1
No	24

Q26 **Were you offered anything to:**

	Yes	*No*
Eat?	21	5
Drink?	15	7

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

I did not have any food or drink	8
Yes	4
No	11

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	1
I was not offered anything to cope with not smoking	19
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	3
No	23

Q30 **Was someone informed of your arrest?**

Yes	12
No	12
I don't know	0
I didn't want to inform anyone	2

Q31 **Were you offered a free telephone call?**

Yes	17
No	9

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

My phone call was not denied	17
Yes	2
No	5

Q33 **Did you have any concerns about the following, whilst you were in police custody:**

	Yes	*No*
Who was taking care of your children	3	14
Contacting your partner, relative or friend	8	12
Contacting your employer	4	14
Where you were going once released	5	12

Q34 **Were you interviewed by police officials about your case?**

Yes	14	
No	12	If No, go to Q35

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

	Yes	*No*	*Not needed*
Solicitor	13	0	2
Appropriate Adult	0	2	5
Interpreter	1	2	6

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

I did not requested a solicitor	9
2 hours or less	3

Over 2 hours but less than 4 hours 3
4 hours or more 8

Q37 Were you officially charged?
Yes 20
No 6
Don't Know 0

Q38 How long were you in police custody *after* being charged?
I have not been charged yet 6
1 hour or less 3
More than 1 hour, but less than 6 hours 3
More than 6 hours, but less than 12 hours 3
12 hours or more 10

Section 3: Safety

Q40 Did you feel safe there?
Yes 17
No 6

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?
Yes 9
No 16

Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply)
I have not been victimised 16
Insulting remarks (about you, your family or friends) 7
Physical abuse (being hit, kicked or assaulted) 3
Sexual abuse 0
Your race or ethnic origin 1
Drugs 5
Because of your crime 5
Because of your sexuality 0
Because you have a disability 0
Because of your religion/religious beliefs 3
Because you are from a different part of the country than others 2

Q43 Were you handcuffed or restrained whilst in the police custody suite?
Yes 6
No 17

Q44 Were you injured whilst in police custody, in a way that you feel was not your fault?
Yes 3
No 21

Q45 Were you told how to make a complaint about your treatment here, if you needed to?
Yes 2
No 20

Section 4: Healthcare

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

Yes 8
No 16

Q48 **Were you able to continue taking your medication whilst there?**

Not taking medication 16
Yes 3
No 4

Q49 **Did someone explain your entitlements to see a healthcare professional, if you needed to?**

Yes 7
No 15
Don't know 1

Q50 **Were you seen by the following healthcare professionals during your time there?**

	Yes	*No*
Doctor	10	14
Nurse	0	20
Paramedic	0	20
Psychiatrist	0	20

Q51 **Were you able to see a healthcare professional of your own gender?**

Yes 3
No 14
Don't know 5

Q52 **Did you have any drug or alcohol problems?**

Yes 10
No 14

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 14
Yes 6
No 4

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

I didn't have any drug/alcohol problems 14
Yes 2
No 7

Q55 **Please rate the quality of your healthcare whilst in police custody:**

	I was not seen by health -care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of Healthcare	13	2	1	5	2	1

Q56 **Did you have any specific <u>physical</u> healthcare needs?**

No 16
Yes 5

Q57 Did you have any specific mental healthcare needs?

No 14

Yes 7

Prisoner Survey Responses for Lambeth Police 2009

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

	Any percent highlighted in green is significantly better	Lambeth Custody Suites	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		26	323
SECTION 1: General Information			
2	Are you a Police detainee?	**96%**	**85%**
3	Are you under 21 years of age?	**0%**	**11%**
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)	**66%**	**34%**
6	Are you a foreign national?	**21%**	**16%**
7	Are you Muslim?	**27%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**17%**	**17%**
10	Have you been in police custody before?	**92%**	**89%**
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 24hours?	**38%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**75%**	**72%**
13	Were you told about PACE?	**54%**	**55%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**50%**	**40%**
15	Could you use a toilet when you needed to?	**92%**	**87%**
16	If you did use the toilet, was toilet paper provided?	**73%**	**54%**
17	Did you share a cell at the station?	**8%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**26%**	**25%**
18b	Ventilation/air quality?	**23%**	**17%**
18c	Temperature?	**9%**	**12%**
18d	Lighting?	**41%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**66%**	**58%**
20	Did staff explain the correct use of the cell bell?	**21%**	**22%**
21	Were you held overnight?	**80%**	**90%**
22	If you were held overnight, were you give**no** clean items of bedding?	**26%**	**34%**
23	Were you offered a shower?	**8%**	**8%**

Key to tables

		Lambeth Custody Suites	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		
24	Were you offered a period of outside exercise?	**4%**	**6%**

Key to tables

		Lambeth Custody Suites	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		
25a	Were you offered anything to eat?	**80%**	**75%**
25b	Were you offered anything to drink?	**69%**	**81%**
26	Was the food/drink you received suitable for your dietary requirements?	**28%**	**40%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**75%**	**77%**
28	Were you offered anything to read?	**12%**	**13%**
29	Was someone informed of your arrest?	**46%**	**43%**
30	Were you offered a free telephone call?	**66%**	**49%**
31	If you were denied a free call, was a reason given?	**29%**	**20%**
32	Did you have ay concerns about:		
32a	Who was taking care of your children?	**18%**	**21%**
32b	Contacting your partner, relative or friend?	**40%**	**57%**
32c	Contacting your employer?	**23%**	**25%**
32d	Where you were going once released?	**30%**	**37%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**86%**	**73%**
34b	Appropriate adult	**0%**	**6%**
34c	Interpreter	**12%**	**9%**
35	Did you wait over 4 hours for your solicitor?	**56%**	**65%**
37	Were you held 12 hours or more in custody after being charged?	**53%**	**66%**
SECTION 3: Safety			
39	Did you feel unsafe?	**27%**	**41%**
40	Has another detainee or a member of staff victimised you?	**35%**	**44%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**27%**	**27%**
41b	Physical abuse (being hit, kicked or assaulted)	**13%**	**17%**
41c	Sexual abuse	**0%**	**2%**
41d	Your race or ethnic origin	**4%**	**7%**
41e	Drugs	**21%**	**17%**
41f	Because of your crime	**21%**	**21%**
41g	Because of your sexuality	**0%**	**0%**
41h	Because you have a disability	**0%**	**3%**
41i	Because of your religion/religious beliefs	**13%**	**3%**
41j	Because you are from a different part of the country than others	**8%**	**5%**
42	Were you handcuffed or restrained whilst in the police custody suite?	**27%**	**50%**

Key to tables

	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	Lambeth Custody Suites	Police custody comparator
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	**13%**	**30%**
44	Were you told how to make a complaint about your treatment?	**10%**	**13%**

Key to tables

		Lambeth Custody Suites	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		
SECTION 4: Healthcare			
46	Were you on any medication?	**33%**	**45%**
47	For those who were on medication: were you able to continue taking your medication?	**43%**	**39%**
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	**30%**	**36%**
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	**41%**	**51%**
49b	Nurse	**0%**	**19%**
49c	Paramedic	**0%**	**2%**
49d	Psychiatrist	**0%**	**3%**
50	Were you able to see a healthcare professional of your own gender?	**14%**	**29%**
51	Did you have any drug or alcohol problems?	**41%**	**58%**
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?	**60%**	**40%**
53	Were you offered relief medication for your immediate symptoms?	**24%**	**33%**
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	**29%**	**29%**
55	Do you have any specific physical healthcare needs?	**24%**	**36%**
56	Do you have any specific mental healthcare needs?	**33%**	**23%**