Inspecting policing in the public interest

Report on an inspection visit to police custody suites in

Metropolitan Police Service Borough Operational Command Unit of Barnet

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

21–23 August 2013

Glossary of terms

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Section 1. Introduction

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

This inspection looked at the one custody suite serving the London Borough of Barnet within the Metropolitan Police Service (MPS). Strategic oversight of the suite was provided centrally by the MPS territorial policing criminal justice directorate, which seeks to ensure consistency in custody provision across all London boroughs. Day-to-day management of custody was delegated to the borough operational command unit commander.

Strategic oversight of custody was poor. Little interaction took place with partners at a strategic level, and there was a lack of senior management oversight of the custody facility. As we found elsewhere in the MPS, use of force was not appropriately monitored in Barnet.

The suite had been refurbished and provided detainees with a decent environment. We saw some good interactions between staff and detainees and good day to day management of a busy suite. However, we were concerned that staff discussed detainees within earshot of other detainees and their relatives, which was disrespectful and potentially breached confidentiality. Although we found some good entries in custody records as part of pre-release risk assessments, entries in other records were perfunctory.

The latest that someone could be seen in court (the court cut-off time) was too early. Although custody staff had little control over this, it potentially had a detrimental effect on detainee welfare.

Nurses were based at the suite, which ensured that detainees who needed health interventions were seen promptly. The nurses liaised well with the local mental health service and we saw some good work to improve the care of detainees with mental health problems. Although custody was rarely used as a place of safety under the Mental Health Act, we were aware that two detainees had recently been brought to the suite under section 136, one during our inspection, as no psychiatric hospital places were available in the area. This was a concern and should be discussed with strategic partners as soon as practicable.

Overall, custody provision in Barnet was reasonable and in the main detainees were treated with respect, but a more strategic focus and better oversight were needed.

This report provides a small number of recommendations to assist the force and the Mayor's Office for Policing and Crime to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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HM Chief Inspector of Constabulary

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February 2014

Section 2. Background and key findings

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

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

2.3 The Metropolitan Police Service (MPS) operates 37 custody suites, 24 hours a day, to deal with the majority of detainees arrested during normal daily policing. A further 12 are reserved as 'overflow custody suites' and are used for various operational purposes. These include: charging centres for football matches; as a fallback when maintenance work requires the closure of another 24-hour suite; to meet other operational demands over and above custody core business; and for Operation Safeguard (overflow from prisons), when activated. In total, the MPS has 51 custody suites designated under the PACE for the reception of detainees.

2.4 Barnet had one custody suite in Colindale, this had undergone a major refurbishment, reopening in December 2012. It had 25 cells.

2.5 During this unannounced inspection we examined force-wide and borough operational command unit (BOCU) custody strategies, as well as treatment and conditions, individual rights and health care. In the financial year 2012–13, there had been nearly 5,500 detainees held in custody in the borough. This was a decline from the previous two years, but year to date figures for 2013–14 indicated that there would be an increase in the number held by the end of the year.

Strategy

2.6 The MPS territorial policing criminal justice directorate had strategic oversight of custody in all London boroughs. The Metropolitan Police Authority was responsible for the custody estate. Responsibility for the day to day management of Barnet's custody suites and delivery of custody services had been devolved to BOCU.

2.7 There was a lack of strategic focus on promoting safe and decent custody. Some staff told us that the senior leadership team was not particularly visible. We noted that the visits register

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

in custody showed only 10 visits in the previous 11 months. There were no custody user group forums. Dip sampling of custody records was sparse.

2.8 Very little interaction took place with partners at strategic level. Barnet had no borough criminal justice board, although the borough was represented at the court user group. There was an active independent custody visitors (ICV) scheme whose members had a good relationship with the police; they reported that issues raised were addressed promptly.

2.9 Police constable gaolers were used as backfill for designated detention officers. They had undergone custody specific training before working in custody, although not all were able to input information onto the MPS custody database, which limited their role.

Treatment and conditions

2.10 Although we found that detainees were treated with respect and that their diverse needs were generally met, we had major concerns about the handling of confidential information.

2.11 Custody staff's interactions with detainees were polite and professional; we observed some excellent de-escalation skills and good management of the busy suite.

2.12 There was little provision specifically for women. Religious needs were not fully catered for: while there were some holy books and artefacts were respectively stored, a Qur'an could not be found. Although one cell had been adapted to comply with the Disability Discrimination Act, a disabled or elderly person would have found it difficult to use the low bed plinth.

2.13 Risk assessments were thorough and used standard custody computer system prompts. Police national computer markers (indicators showing that a person has previously had a drug problem or attempted to harm themselves or escape, for example) were seen before risk assessment were carried out. Custody sergeants questioned detainees appropriately when vulnerabilities and risks were disclosed. Risk management was proportionate, with the full range of observations applied. Staff were well versed in the principles of the 4-Rs (rousing procedure as set out in annex H to code C in the Police and Criminal Evidence Act 1984), which our analysis of custody records confirmed. We observed staff handovers involving discussions about those in custody taking place within the hearing of both detainees and their relatives. Some pre-release risk assessments were perfunctory, while others demonstrated that detainees' needs had been considered; a consistent approach was needed.

2.14 Use of force in custody was not recorded except on an individual's custody record.

2.15 The refurbished suite provided accommodation that was clean, safe and mostly in a good state of repair, and cells were checked every day. However, some cells were not being used. The suite had a good stock of replacement clothing and footwear, plenty of blankets, mattresses and pillows, a range of reading material and an exercise yard. A suitable range of meals was available, including Kosher meals.

Individual rights

2.16 Detainees were informed of their rights and could exercise them while in custody. Staff told us that street bail[2] and voluntary attendance, known as Caution Plus 3, were used as alternatives to custody. We were informed that immigration detainees were not held for unduly long periods. However, we were not provided with data and some staff told us that they thought the time immigration detainees stayed in custody had increased. There were suitable arrangements made for the provision of Appropriate Adults (independent individuals who provide support to young people and vulnerable adults in custody). Reviews were mostly carried out face to face with the detainee, although not all occurred on time. Court cut-off times were too early. Not all staff were aware of the correct procedure for a detainee to make a complaint about their time in custody.

Health care

2.17 A nurse was available in the suite 24 hours a day and detainees were seen promptly. Nurses provided custody staff with timely information to ensure detainee safety, but there were sometimes unnecessary delays in getting advice and support from the forensic medical examiner. General health and fitness to interview and detain assessments were completed appropriately, but we were concerned that detainee privacy and confidentiality were routinely compromised. Medications were stored and administered appropriately; however, detainees with prescribed maintenance therapy for substance misuse could only receive symptomatic relief.

2.18 The substance misuse team offered detainees with substance misuse problems, including those released out of hours, a prompt effective service. Mental health assessments and advice were provided by the on-call approved mental health professional team. Custody staff and nurses told us that the team usually responded promptly; we observed the team's response to two requests from custody staff that confirmed this.

2.19 The custody suite was rarely used to detain people with mental health problems, but we observed one detainee with mental health needs arrive in custody.

Main recommendation

2.20 The MPS should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and learn lessons.

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

Section 3. Strategy

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

Strategic management

3.1 A commander led the Metropolitan Police Service (MPS) territorial policing criminal justice (TPCJ) directorate. A superintendent was responsible for the day-to-day management of the TPCJ. The Metropolitan Police Authority was responsible for the custody estate.

3.2 Responsibility for the day-to-day management of Barnet's custody suite and custody services had been devolved to the borough operational command unit (BOCU), for which the BOCU commander, a chief superintendent, was responsible. The Mayor's Office for Policing and Crime did not take the lead on custody at the MPS.

3.3 The TPCJ was responsible for inspections for audit and compliance purposes and to ensure health and safety and the implementation of the *Authorised Professional Practice - Detention and Custody,* published by the College of Policing.

3.4 Policies were signed off at a strategic command level in the MPS, and the TPCJ provided standard operating procedures (SOPs) that supported the delivery of force policies in each MPS custody suite. The SOPs covered a broad spectrum, including use of police custody, use of CCTV and guidance for custody staff on the supervision of detainees. They were designed to assist BOCUs in delivering a consistent service.

3.5 The borough commander exercised strategic leadership of the custody function for the borough of Barnet. A chief inspector of operations from the senior leadership team (SLT) led the custody function, managing a custody manager who was an inspector. There was limited evidence that SLT members visited the custody suites and staff told us that they were not particularly visible.

3.6 The TPCJ maintained an organisational risk register for all MPS custody suites. The BOCU commander was responsible for implementing local work on risks and introducing measures to mitigate them. The borough risk register had not been updated for some considerable time and several control measures were not in place. A register of SLT visits to custody to oversee risk management showed an average of less than one visit per month and a six month period during which no checks had been recorded.

3.7 The borough had one designated full-time custody suite in Colindale, which had 25 cells. Although Colindale had a custody manager, we were told that he was regularly required to cover the duty officer role, taking him away from custody duties.

3.8 Staffing in the custody suite was adequate and consisted of 12 permanent custody sergeants who were managed by the custody manager. We were told that backfill sergeants were used infrequently to cover absences, which was good.

3.9 Custody sergeants were supported by permanent designated detention officers (DDOs), whom they line managed. DDOs, who took on the care of detainees, had received training. They booked detainees in under the supervision of custody sergeants, which we witnessed during our inspection.

3.10 Although we were told that the borough had the required number of DDOs in post, the borough made considerable use of police constable (PC) gaolers during our inspection. Many did not have access to the custody computer system because they had not received training, which restricted their role. We saw them asking DDOs to make entries on the custody computer system, distracting DDOs from their own duties.

3.11 A member of the SLT chaired 'pacesetter' meetings, which took place every day to speed up investigations; they were attended by the custody chief inspector who could raise custody issues as necessary. Custody was also discussed when necessary at the daily SLT meeting. The custody chief inspector liaised informally with the custody manager on a regular basis. Custody health and safety matters were discussed at the quarterly BOCU health and safety meeting. There was no custody user group where practitioners could discuss custody issues.

3.12 The custody manager was expected to check a sample of custody records as part of the process to assure the quality of custody work. Despite there being a requirement for the custody manager to dip sample around 10% of custody records, this was not being achieved. For example, in June 2013, only one per cent of records were dip sampled (five records) and the borough could not show us records of any other dip sampling. The borough used the MPS template for dip sampling custody records, which was comprehensive and included checking person escort record forms and CCTV recordings. Dip sampling included staff handovers, which the custody manager attended whenever possible.

3.13 There were processes for dealing with successful interventions (an intervention to an incident with a successful outcome), based on a form passed on to the custody manager, custody chief inspector and TPCJ. Successful interventions were an agenda item at the quarterly health and safety meeting. Lessons learned from successful interventions were communicated to staff either face to face or via email. Independent Police Complaints Commission *Learning the Lessons* information was put on the force intranet, and managers expected staff to visit the site regularly for updates (see section on treatment and conditions, paragraph 4.13).

Recommendations

3.14 The borough should ensure that custody risks are effectively managed and that the SLT maintains ownership and oversight of the risks and control measures.

3.15 The custody manager should be dedicated to the role and should not be used to cover absences elsewhere.

3.16 The borough should ensure that there is a process in place to ensure that a representative number of custody records are quality assured each month.

Housekeeping point

3.17 The borough should introduce a custody user group so that custody practitioners can discuss custody issues.

Partnerships

3.18 There was little regular interaction with partners at a strategic level and there was no borough criminal justice board, although the borough was represented at the court user group. There was also little engagement with partner organisations at an operational level.

An established independent custody visitor (ICV) scheme covered Barnet, with weekly visits to the suite. ICVs said that immediate issues were dealt with effectively and that they received feedback on outstanding issues. Police regularly attended panel meetings.

Housekeeping point

3.19 There should be engagement with partners at strategic and practitioner levels through regular meetings.

Learning and development

3.20 All DDOs and custody sergeants on custody duties had received training before working in custody. PC gaolers had received custody specific computer-based training before working in custody, although many had not received training on the custody computer system. A large number of different PC gaolers were being used in custody and it was evident during the inspection that some did not have the necessary knowledge or skills to carry out the role effectively, which posed a potential risk. Custody sergeants received yearly mandatory training, and staff we spoke with had either received this training or were scheduled to attend it.

3.21 The borough did not produce a custody newsletter, and although staff could view the TPCJ website highlighting MPS-wide issues and providing guidance on SOPs, they told us it was not the first place they looked for information. There was an onus on custody-trained sergeants to apply for refresher training; the borough did not have sufficient oversight of the training records of staff working in custody.

Recommendation

3.22 PC gaolers should have received custody-specific training, including how to access the custody computer system database, before working in custody.

Housekeeping point

3.23 There should be oversight of training records for staff working in custody to ensure their training is up to date.

Section 4. Treatment and conditions

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

Respect

4.1 Custody staff generally interacted with detainees politely and professionally, although we had concerns about the handling of confidential information during staff handovers (see section on safety). We observed a custody sergeant use excellent de-escalation skills with three particularly difficult detainees. Despite the stressful situation, the sergeant remained fully in control of the suite and orchestrated staff responses professionally.

4.2 Screens between the four booking-in terminals provided limited privacy and detainees could receive phone calls in a private booth. There was a separate booking-in room, but we did not see it being used despite the need for it on one occasion when a very vulnerable detainee, held under section 136 of the Mental Health Act, was being booked-in. Clearly unwell, she appeared afraid and was reticent about answering the custody sergeant's questions in the busy booking-in area.

4.3 There was little provision specifically for women. A female detainee was not offered hygiene products or the chance to speak with a woman officer, despite staff saying that women were routinely offered these. A woman who had removed all her clothes could be seen by male officers via CCTV monitors; CCTV was unnecessary because she was subject to a close proximity watch.

4.4 We were told vulnerable young people might be allowed to wait in a consultation room with an appropriate adult (AA). Our custody record analysis (CRA) found that only one young person was held overnight for just over 43 hours. It was the first time he had been in custody. His record noted that following charge, the young person was denied bail; there was no record of any attempt to secure alternative accommodation for him. The young person received regular meals, but was not offered access to washing facilities, the opportunity to exercise or any reading material. He was allowed a telephone call to his uncle, who acted as his AA just prior to going to court.

4.5 There was a prayer mat, but no Qur'an and no means of determining the direction of Mecca. There were numerous other holy books, including the Bible and Torah. Detention officers were aware of the importance of offering transgender detainees a choice about who searches them. One cell was compliant with the Disability Discrimination Act. It had a low call bell that could be reached from the floor, although it also had a low bed plinth from which elderly or disabled detainees might have had difficulty getting up from. Staff said there was a hearing loop in the booking-in area, but they did not know how to use it.

Recommendations

4.6 Booking-in areas should provide sufficient privacy to enable staff and detainees to communicate effectively.

4.7 Staff should ensure that items needed for religious observance, including the Qur'an, are available and offered.

4.8 The specific needs of young people, women and detainees with disabilities should always be met

Housekeeping points

4.9 Care should be taken to ensure the privacy of detainees who are undressed.

4.10 Staff should be briefed about how to use all relevant equipment, including the hearing loop.

Safety

4.11 Risk assessments were thorough and the standard custody computer system prompts were used. Police national computer markers were checked before risk assessments were completed. Our custody record analysis (CRA) showed that the small number of detainees for whom a risk assessment could not immediately be made due to intoxication were subject to frequent observations. Custody sergeants questioned detainees appropriately when vulnerabilities and risks were disclosed. Additional information was also noted, such as assessments of detainees' mood and demeanour. Risk management was proportionate and the full range of observations applied. For eight detainees (27%) in our CRA, it was their first time in custody. All were appropriately placed on 30-minute visits. Some could keep cords and spectacles, subject to risk assessment, which was good practice. A custody sergeant prepared a helpful briefing, using a standard Metropolitan Police Service (MPS) form, for an officer undertaking a constant watch, which the officer used to record any significant events.

4.12 The MPS 4-Rs were used to remind designated detention officers (DDOs) of the procedures to be used when making rousing checks; they were aware of the need to obtain a response that demonstrated consciousness. Our analysis of 30 custody records found that staff varied questions and commands when undertaking rousing checks.

4.13 We were concerned to find that although custody sergeants knew about the Independent Police Complaints Commission *Learning the Lessons* bulletins, they had difficulty accessing them or other information about adverse incidents on the MPS intranet. Some told us that information about adverse incidents had been disseminated through an occasional custody bulletin, which they had found helpful.

4.14 Cell keys had single-use ligature knives attached, and all DDOs carried ligature knives, sealed in plastic, on their belts. Call bells sounded clearly in the booking-in area and received a prompt response. Some, but not all, detainees could recall being told how to use them.

4.15 Most shift handovers were thorough, although some important information about detainee care was not passed on (see paragraph 4.31). We were concerned that little attempt was made to ensure confidentiality, and we observed more than one serious and easily avoidable breach of confidentiality. One handover was undertaken in front of a detainee being bailed, during which detailed information about another detainee's medical condition was imparted. There was no satisfactory explanation for handovers not being conducted privately, as facilities were available. An evening handover was delayed by one hour while custody sergeants attempted to resolve a problem with a custody record, delaying the transfer of a very sick female detainee to hospital: ambulance staff were kept waiting almost two hours. The handover was also carried out within earshot of a detainee's relatives.

4.16 Custody sergeants carrying out pre-release risk planning had to return to the original risk assessment on the custody computer system before they could close a custody record. They gave detainees a leaflet containing the standard MPS list of support agencies and explained the purpose of the leaflet to each of them. An additional leaflet for ex-service personnel was also available, which was good practice. Officers offered vulnerable detainees a lift home, and one custody sergeant had arranged for a vulnerable detainee with no money to be taken by officers to Paddington Station and given a train ticket. Safeguarding concerns were referred to specialist child protection officers, whom staff said were helpful and always available.

4.17 Our CRA showed that some pre-release risk assessments were perfunctory, simply stating that there were no issues. In three cases detainees were released late at night without officers considering how they would return home. In only a few cases the risk assessment recorded how the detainee would get home. One detainee required an AA during their interview due to depression. The detention log noted that the detainee was 'perfectly capable of looking after herself and functioning without assistance'; she was offered the opportunity to see a health care professional (HCP) before being released, but declined.

Recommendations

4.18 Handovers should take place promptly at the start of each shift in an area that is cleared of other staff and detainees.

4.19 Pre release risk assessments should be comprehensive and record all relevant issues and actions taken

Use of force

4.20 Most, but not all, detainees arrived in handcuffs. They were generally removed in the holding room or at the desk before booking in commenced. However, we saw two instances where detainees were held in cuffs for longer for no apparent reason. One detainee was difficult to manage; he was kept handcuffed in the holding room for over an hour while waiting to be booked in. He complained repeatedly about the cuffs hurting him and officers could have offered him the opportunity to become compliant by removing the cuffs.

4.21 As in other MPS boroughs, there was no use of force form. Where detainees had been handcuffed, custody sergeants examined their wrists, recorded the collar numbers of officers involved and the handcuff numbers in the detainee's custody record (see main recommendation, paragraph 2.20).

4.22 Seven detainees (23%) in our CRA came into custody with injuries, which included marks where handcuffs had been used and cuts and bruises from incidents occurring before they entered custody, as well as self-inflicted injuries. Four saw an HCP and their injuries were noted. One detainee left after two hours and 26 minutes, none of the others saw an HCP, and in one case no reason was given.

4.23 We did not see any detainees being strip-searched. Six detainees (20%) in our CRA had been strip-searched, which had been authorised in all but one case, where authorisation was unclear. Strip-searches were in most cases carried out because the detainee was suspected of possessing drugs; in one instance it was thought the detainee might have an object that could be used in a threatening or violent way.

4.24 DDOs received refresher personal safety training every year that included instructions on new methods of restraining young people, pregnant women and others.

Physical conditions

4.25 The suite had been refurbished and cells were fairly clean, although the flooring contained some ingrained dirt. There was a small amount of graffiti on bed plinths and cell door hatches. DDOs wiped down mattresses with anti-bacterial wipes between uses. A cleaning contractor, who normally arrived within two hours of being called, was used for clearing up bodily fluid spillages. However, it was inappropriate to mark one job as involving 'HIV and Hep C' on the record. There were ample consultation and interview rooms, all of which were clean and well equipped.

4.26 Showers were reasonably clean, offered good privacy and hot water. However, the prevalence of male DDOs might have made female detainees reluctant to have a shower. In our CRA, four detainees (13%) who were transferred straight to court were not offered showers. They had been in custody for between 13 and 43 hours.

4.27 Cells had toilets but no wash basins, which were in the corridors. Detainees who wanted to wash their hands after using the toilet would have to wait until staff were available to unlock them. The toilet areas were appropriately obscured on CCTV monitors, but detainees were not told that they could not be seen when using the toilet.

4.28 Maintenance arrangements were good; however, many cells had cracked tiles that could have become hazardous and staff told us that some cells were often out of use as a result. There was a complete record of daily cell checks. Good stocks of handcuffs and keys were available. Records showed there had been an evacuation in December 2012, but no evacuation drills had been recorded or could be recalled by staff.

Detainee care

4.29 Stocks of replacement clothing and plimsolls were good. Paper suits were also available, although we only saw detainees in track suit bottoms and t-shirts. There were plenty of blankets, mattresses and pillows, all in good condition. A good stock of cotton towels for showers was available, as well as supplies of soap and toothbrushes, but there were no razors. Toilet paper was not available in cells so detainees had to ask for it, which was demeaning.

4.30 Breakfast and lunch were supplied through the police station canteen on week days. At other times, detainees received microwave meals. There was a good selection of vegetarian and halal options and all were within their sell-by dates. The local rabbi brought in Kosher meals that were kept in a separate fridge. Microwave ovens were not very clean.

4.31 A female detainee in poor health told staff she required a vegan, gluten-free diet. Although this was recorded in her custody record, the information was not passed on to staff on the next shift. Staff were unaware of it and vague about what they could offer her.

4.32 An exercise area was covered and reasonably clean. Staff said they tried to offer exercise to anyone in custody for more than 24 hours.

4.33 There was a very good stock of books, including some for young people, but none in other languages except Japanese. We saw no detainees being offered reading material. Three detainees (10%) were provided with reading material, although it was not recorded if the detainees requested or were offered it. One detainee, held for over 43 hours, was not offered reading material.

4.34 Staff informed us that vulnerable detainees were very occasionally offered visits. We saw detainees being allowed to telephone friends and family in private.

Housekeeping points

4.35 Staff should ensure information about detainees' dietary needs is passed on at handover.

4.36 A range of reading material should be available and routinely offered, including books and magazines suitable for those whose first language is not English.

Section 5. Individual rights

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

Rights relating to detention

5.1 We observed some queuing in the holding area on our first day. The suite was dealing with some particularly vulnerable detainees and staff worked effectively to manage the demand. One of the custody sergeants was especially effective in maintaining control. Generally, we observed detainees being booked in reasonably promptly and waiting no more than 10-15 minutes.

5.2 Custody sergeants checked the reasons for detention with arresting officers to ensure that they were appropriate. However, custody sergeants could give no examples of detention being refused. One said: 'The necessity test is the arresting officer's decision to make.' Some custody officers told us that the new 'Grip and Pace' process (involving daily meetings to move forward on investigations) had led to officers bringing detainees into the suite without sufficient information to justify the arrest; they had been instructed to make the arrest but had not been given detailed information about the case. As a result, numerous enquiries had to be made to determine the next course of action, which could have increased the length of time a person spent in detention.

5.3 Custody and operational staff stated, however, that there was a renewed emphasis on dealing with suspects, where appropriate, through street bail and voluntary attendance, known as Caution Plus 3. However, the borough could not provide any data on the number of Caution Plus 3 attendees nor did we observe any detainees being interviewed under the system.

5.4 Solicitors said custody staff were professional in their dealings with detainees. Custody sergeants were clear about their obligations to ensure that cases proceeded quickly but stated that there were often problems with staff availability. A detective commented that the resources to deal with detainees at night were not sufficient due to operational requirements, which could prolong a detainee's time in custody. Although we did not observe evidence of this during the inspection, custody staff told us that arresting officers often failed to consider the availability of staff to move an investigation forward once an arrest had been made.

5.5 The custody record analysis (CRA) indicated that 30% of detainees were held for less than six hours and 33% were detained overnight, which supported staff's contention that progress on cases was not being made at night. The average detention time was 12 hours and 37 minutes.

5.6 Custody staff told us they had good relationships with Home Office staff. The data provided by TPCJ showed an average of 99 immigration detainees a year between April 2010 to March 2013, with a further 37 immigration detainees for the year to date. We did not receive data on their average time in custody, but custody staff believed that this had increased since the borough Nexus immigration team (a joint initiative between the MPS and the Home Office to share intelligence about foreign national offenders) had merged with the case progression unit.

5.7 Staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989.

5.8 The MPS provided all under-18s with an appropriate adult (AA) in anticipation of legislative changes[3]. A 17-year-old was still permitted to decline an AA, but only once the AA had attended and had had the opportunity to speak to the detainee. Family members were usually contacted initially to act as an AA, but failing this, an AA service was available from 8am to 10pm, seven days a week. This scheme was also available for vulnerable adults. Some staff stated that AAs from the scheme did not always attend the station promptly.

5.9 In the CRA of young people (10 cases), all but one recorded the presence of an AA. In that case involving a 17-year-old, there was no record of an AA being offered and no AA was recorded as having attending before the detainee was released. Six young people were detained longer than six hours, one of whom was held for over 43 hours.

5.10 Custody staff informed us that they would try not to detain children in police custody overnight and would attempt to contact social services to arrange accommodation for them, although they said they were always informed that none was available. In the CRA case of the young person in police custody for over 43 hours, no record of any attempt to transfer the young person to local authority accommodation had been made following the refusal of bail.

5.11 Leaflets about legal rights were available in several languages and were easily accessible on the computer system. There was no material in Braille or in pictorial or easy read formats. A professional telephone interpreting service was available to aid the booking-in process. Staff said there was a good face-to-face interpreter service available for interviews.

Recommendations

5.12 The borough operational command unit should ensure that where pre-planned arrests are undertaken, sufficient staff are available to move the enquiry forward, reducing the time a detainee is in police detention.

5.13 The MPS should engage with the local authority to ensure the provision of safe beds for children and young people who have been charged but cannot be bailed to appear in court.

Housekeeping points

5.14 Arresting officers for pre-planned arrests should be better briefed to ensure that both they and custody sergeants can meet their obligations within Police and Criminal Evidence Act (PACE) G code of practice by exploring alternatives to custody and detention before making an arrest.

5.15 The borough should maintain data on people dealt with through voluntary attendance at the police station.

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[3] Except for PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

Rights relating to PACE

5.16 The criminal defence service poster advising detainees of their right to free legal advice was displayed prominently in the booking-in area at Colindale. The poster had entries in many languages.

5.17 Detainees at Colindale could speak privately to solicitors on the telephone in a glass-fronted sound-proof booth that was visible from the custody desk. The suite also had consultation rooms so that solicitors could speak to clients privately in person.

5.18 Detainees' right to free legal representation was clearly explained to them. Those who declined the offer were asked why and reminded that they could change their mind at any time. Solicitors were contacted promptly. Our observations during the inspection confirmed this. Our CRA showed that all detainees were offered the services of a solicitor and 60% accepted.

5.19 Detainees were advised that they could have someone told of their whereabouts and informed that they could read the PACE codes of practice, up-to-date copies of which were readily available at the custody suite. Legal representatives, who could easily obtain copies of detainees' custody records, said they had a positive relationship with the police and considered that PACE issues were applied efficiently and fairly.

5.20 We observed police inspectors from response teams undertaking PACE reviews of detainees in custody in person. Of the 18 initial inspector PACE reviews in the CRA, 12 were conducted face to face and three while the detainee was asleep; it was unclear whether the review process undertaken was later explained to the detainee who had been asleep. Telephone reviews were rare. Three reviews were conducted late, two because the inspectors were in operational meetings.

5.21 The handling and processing of DNA and forensic samples were well managed and the procedure for the prompt collection of samples was effective.

5.22 We were told that court cut-off times could be as early as 1pm on week days, which was unacceptably early, and 10am on a Saturday. The escort contractor was unlikely to dispatch a vehicle to transport detainees who became available for court after the morning collection, and we observed strenuous efforts to arrange a police officer transfer for one detainee so that they could reach court before the 1pm deadline.

Recommendation

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

Housekeeping point

5.24 All custody records should indicate that the detainee has been reminded that a review of their detention was conducted while they were asleep or otherwise engaged and had their rights and entitlements reaffirmed.

Rights relating to treatment

5.25 Although senior management expected an inspector to take detainees' complaints while they were still in custody, we were told the usual advice was that the detainee would have to report to the front desk after release or make a complaint online. Detainees were not told how to make a complaint and no details about complaints procedures were displayed in custody suites; however, information was contained in the leaflet handed to detainees during the booking-in process.

Recommendation

5.26 Detainees should be able to make a complaint about their care and treatment before they leave custody.

Section 6. Health care

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

Governance

6.1 Health care was provided by the Metropolitan Police Service (MPS). Barnet Enfield and Haringey Mental Health NHS Trust provided mental health services and Westminster Drugs Project (WDP) ran substance use services.

6.2 Custody nurses were at the suite 24 hours and had access to an on-call forensic medical examiner (FME). There were some gaps in nursing cover related to nurses travelling from outside the borough. Most detainees were seen swiftly but FMEs did not always respond promptly. We observed how a nurse failed to receive a response from an FME within a reasonable time (see paragraph 6.12).

6.3 There was a dedicated clinical room; it was clean and suitable with facilities for consultation and forensic examination, but privacy was compromised (see paragraph 6.11). There was access to the custody computer system and nurses recorded consultations on eCHAPs, the electronic clinical information system, and the medical form so that custody staff could be informed of detainees' fitness to be held and interviewed and key health risks.

6.4 One resuscitation kit, including a defibrillator, was kept by the custody desk with further kits stored in the clinical room. One oxygen cylinder was half empty. There were some gaps in daily equipment checks. A machine to determine 'life extinct' was available, but nurses were not yet trained to use it. Custody staff had received emergency life support training. A dual handset was available for language interpretation.

6.5 Nurses received induction training and two days' refresher training annually. Opportunities to enhance their clinical skills were limited. Not all nurses had received their annual performance development review, and there was no formal arrangement for clinical supervision or line management meetings.

Recommendations

6.6 Medical advice should always be provided within the agreed timescale.

6.7 Resuscitation kits should be checked and restocked promptly.

Housekeeping point

6.8 Nurses should have regular line management and supervision meetings and training should be aligned to service and development needs.

Patient care

6.9 All detainees were asked whether they wanted to see a health care professional, and nurses identified from the detention list whom to see and in which order. There was no evidence that nurses proactively identified detainees with possible health needs.

6.10 Consultations followed a template. Paper body maps were used and stored in locked cabinets. Assessment templates determined referrals to mental health services and those for opiate and alcohol withdrawal. Detainees being transferred to hospital were asked for their consent to share information. Patient advice leaflets on head injuries were available.

6.11 We observed several consultations conducted with the clinical room door open onto a busy corridor with other detainees visible and within earshot. A designated detention officer stood outside. Nurses said this was standard practice; they appeared to place more emphasis on the security risk than on the privacy and dignity of the patient. Custody staff regularly interrupted consultations, breaching confidentiality by imparting information about other detainees in front of the person being examined. We were also concerned that some nurses appeared inappropriately judgemental in their approach to detainees.

6.12 We observed one detainee with significant health issues and behavioural challenges being offered good care. An intimate examination was conducted sensitively in a cell; although the examination was not visible on the CCTV, the monitor should have been switched off. The nurse was unable to obtain a FME response and appropriately, the detainee was taken to hospital.

6.13 Detainees on prescribed medication could take their own medicines and regular or urgent medication was collected from detainees' homes wherever feasible. Nurses could verify patients' own prescriptions with their GP and administer most common medications from a good range of patient group directions (which enable nurses to supply and administer prescription-only medicine). It was good that nurses could administer a maximum of three doses without a prescription.

6.14 Detainees with a history or clinical indications of alcohol or drug withdrawal were only given symptom relief, even if they usually received prescribed maintenance therapy. We were told that FMEs could administer methadone, but we did not see this happening.

6.15 Medicines were stored in a locked cupboard by the custody desk, to which only nursing staff had access through a key stored in a digitally locked safe. Stock balances of diazepam and dihydrocodeine were accurate and regularly recorded. Administration of controlled drugs by nurses had to be witnessed by custody staff. A checking schedule for medicine stocks and forensic kits had gaps of up to a month during which no checks were recorded.

Recommendation

6.16 Patient confidentiality should always be maintained unless the assessed risk or an emergency, determines otherwise

Housekeeping point

6.17 Checks of equipment, medicines and forensic kits should be completed and recorded regularly.

Substance misuse

6.18 Westminster Drug Project workers offered substance use services in the suite between 7am and 9pm, Monday to Friday. An early morning cell sweep was conducted and positive tests prioritised. At weekends and overnight, custody staff could use a dedicated single point of contact telephone number to make referrals; these received a response on the earliest working day.

6.19 Workers had constructive relationships with custody and nursing staff and provided a verbal handover disclosing key issues. Detainees held for specified offences were subject to discretionary testing. Workers explained that in some instances no clear decision was made regarding whether a detainee should be tested before they left police custody.

6.20 Young people were seen and referred to designated local young people's services.

Recommendation

6.21 All decisions to test for trigger offences should be timely and clearly recorded on the custody computer system.

Mental health

6.22 There was no dedicated mental health service, but the custody nurse or FME referred detainees requiring assessment to the local approved mental health professional (AMHP) team. We observed the team visiting to assess two detainees, and custody and nursing staff told us they were responsive and provided advice.

6.23 Data from the force indicated that only three people had been detained in police custody under section 136 of the Mental Health Act since April 2013; we were told that anyone requiring admission would be transferred to Chase Farm Hospital. One detainee was held under section 136 during our visit and was seen by the AMHP team with no hospital admission required.

6.24 Juvenile detainees were seen with an appropriate adult.

Section 7. Summary of recommendations

Main recommendation

7.1 The MPS should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and learn lessons. (2.20)

Recommendations

Strategy

7.2 The borough should ensure that custody risks are effectively managed and that the SLT maintains ownership and oversight of the risks and control measures. (3.14)

7.3 The custody manager should be dedicated to the role and should not be used to cover absences elsewhere. (3.15)

7.4 The borough should ensure that there is a process in place to ensure that a representative number of custody records are quality assured each month. (3.16)

7.5 PC gaolers should have received custody-specific training, including how to access the custody computer system database, before working in custody (3.22)

Treatment and conditions

7.6 Booking-in areas should provide sufficient privacy to enable staff and detainees to communicate effectively. (4.6)

7.7 Staff should ensure that items needed for religious observance, including the Qur'an, are available and offered. (4.7)

7.8 The specific needs of young people, women and detainees with disabilities should always be met (4.8)

7.9 Handovers should take place promptly at the start of each shift in an area that is cleared of other staff and detainees. (4.18)

7.10 Pre release risk assessments should be comprehensive and record all relevant issues and actions taken. (4.19)

Individual rights

7.11 The borough operational command unit should ensure that where pre-planned arrests are undertaken, sufficient staff are available to move the enquiry forward, reducing the time a detainee is in police detention. (5.12)

7.12 The MPS should engage with the local authority to ensure the provision of safe beds for children and young people who have been charged but cannot be bailed to appear in court. (5.13)

7.13 Senior police managers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.23)

7.14 Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.26)

Health care

7.15 Medical advice should always be provided within the agreed timescale. (6.6)

7.16 Resuscitation kits should be checked and restocked promptly. (6.7)

7.17 Patient confidentiality should always be maintained unless the assessed risk or an emergency, determines otherwise. (6.16)

7.18 All decisions to test for trigger offences should be timely and clearly recorded on the custody computer system. (6.21)

Housekeeping points

Strategy

7.19 The borough should introduce a custody user group so that custody practitioners can discuss custody issues. (3.17)

7.20 There should be engagement with partners at strategic and practitioner levels through regular meetings. (3.19)

7.21 There should be oversight of training records for staff working in custody to ensure their training is up to date. (3.23)

Treatment and conditions

7.22 Care should be taken to ensure the privacy of detainees who are undressed. (4.9)

7.23 Staff should be briefed about how to use all relevant equipment, including the hearing loop. (4.10)

7.24 Staff should ensure information about detainees' dietary needs is passed on at handover. (4.35)

7.25 A range of reading material should be available and routinely offered, including books and magazines suitable for those whose first language is not English. (4.36)

Individual rights

7.26 Arresting officers for pre-planned arrests should be better briefed to ensure that both they and custody sergeants can meet their obligations within Police and Criminal Evidence Act (PACE) G code of practice by exploring alternatives to custody and detention before making an arrest. (5.14)

7.27 The borough should maintain data on people dealt with through voluntary attendance at the police station. (5.15)

7.28 All custody records should indicate that the detainee has been reminded that a review of their detention was conducted while they were asleep or otherwise engaged and had their rights and entitlements reaffirmed. (5.24)

Health care

7.29 Nurses should have regular line management and supervision meetings and training should be aligned to service and development needs. (6.8)

7.30 Checks of equipment, medicines and forensic kits should be completed and recorded regularly. (6.17)

Section 8. Appendices

Appendix I: Inspection team

Elizabeth Tysoe	HMIP team leader
Gary Boughen	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC lead staff officer
Mark Ewan	HMIC staff officer
Majella Pearce	HMIP health services inspector
Nicola Rabjohns	HMIP health services inspector
Rachel Murray	HMIP researcher
Joe Simmonds	HMIP researcher