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

18–20 June 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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

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1. Introduction

This report is part of a programme of 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.

The City of London police had a good structure of staff and custody user meetings, and there was healthy interaction between the force and both the Police Committee of the City Corporation and the independent custody visitors. However, systematic management oversight was lacking in key risk areas such as safety checks, quality assurance of custody records and staff handovers. Because custody sergeants were not permanent, there was a risk of inconsistency in the day-to-day supervision of police staff gaolers.

Treatment was appropriate and respectful, but there was insufficient control of the cells area. There was no privacy for those booked in and limited provision for minority groups. Risk assessments were thorough, but although risk was reasonably well managed, handovers were not sufficiently well organised or comprehensive. The use of handcuffs was proportionate. The suites were reasonably clean and in good condition, but the booking-in area at Bishopsgate was worn and unkempt, and outdated at Snow Hill. Showers were offered infrequently, and they were not sufficiently private. Detainees were unable to take exercise or receive visits, and although pre-release arrangements were generally good, detainees were not provided with petty cash to cover their fares home. Food and drink provision was good.

Staff were respectful to detainees and treated them with dignity. Custody was not used disproportionately, and there was increasing use of voluntary attendance. The appropriate adult service was good and interpretation was used when necessary. Immigration detainees were moved on without long delays, and PACE procedures were efficiently carried out. Complaints were not dealt with in accordance with policy.

There was good cover by nurses but clinical rooms were in a poor state, and the equipment within them was not properly managed. There were shortfalls in the management of medicines. The level of performance in the delivery of the health care contract was not being sufficiently examined, but the substance misuse service was working effectively. Working relationships with the mental health trust were good but there was a need for a diversion/liaison service and better organisation of section 136 procedures.

Those held in police custody in the City of London were held in reasonably good conditions and were treated well. Their individual rights were respected and upheld. The quality of health care provision was reasonable but it was undermined by some flaws in everyday procedures. The main gap in the management of the custody suites was the lack of systematic and recorded checking by managers that the custody function was being carried out efficiently. This report sets out a small number of recommendations that we hope will help the City of London Police and the Corporation of the City of London to improve the facilities 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
August 2012

Nick Hardwick
HM Chief Inspector of Prisons

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 *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) 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 City of London police had one full-time designated custody suite at Bishopsgate police station with 15 cells, and one stand-by suite at Snow Hill with seven cells. The inspection team visited both custody suites. The force had held 4,281 detainees in the year to 31 March 2012, and 177 detainees for immigration matters in the same period.

2.4 An HM Inspectorate of Prisons researcher and inspector carried out a survey of prisoners at HMP Wandsworth who had formerly been detained in the Bishopsgate or Snow Hill custody suites (see Appendix II).[2]

Strategy

2.5 Governance structures were appropriate: the assistant commissioner led a quarterly organisational learning forum, and both monthly and weekly oversight meetings at which custody was regularly discussed. The chief inspector led a custody user group, which had good staff representation. There was a dedicated custody inspector but no dedicated custody sergeants; some sergeants undertook this duty only rarely. The custody inspector's active oversight of the suites was not clearly evidenced.

2.6 Partnership working was good, both at the London-wide level and through the City of London Criminal Justice Board, as was cooperation with courts and the Crown Prosecution Service.

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

[2] **Inspection methodology:** There are five key sources of evidence for inspection: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections, we use a mixed-method approach to data gathering, applying both qualitative and quantitative methodologies. All findings and judgements are triangulated, which increases the validity of the data gathered. Survey results show the collective response (in percentages) from detainees in the establishment being inspected compared with the collective response (in percentages) from respondents in all establishments of that type (the comparator figure). Where references to comparisons between these two sets of figures are made in the report, these relate to statistically significant differences only. Statistical significance is a way of estimating the likelihood that a difference between two samples indicates a real difference between the populations from which the samples are taken, rather than being due to chance. If a result is very unlikely to have arisen by chance, we say it is 'statistically significant'. The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance. (Adapted from Towel et al (eds), *Dictionary of Forensic Psychology*.)

The police committee of the Corporation, and the independent custody visitors (ICVs), appreciated the responsiveness of the force and the ready access which they were given to the suites.

2.7 The custody manager carried out some quality checking of custody records, and these checks were well used for developing new staff and identifying issues; however, there was neither a consistent monitoring routine for this nor regular recording, and records were not cross-checked with closed-circuit television (CCTV). Staff handovers were not covered by the quality checking process. Training arrangements were adequate but the learning from incidents was not effectively fed back into training. A custody web page on the force intranet provided some useful information but there was insufficient use of this resource to provide easy reference for staff to important information.

Treatment and conditions

2.8 The treatment of detainees was appropriate and respectful, and sergeants regularly explained procedures to detainees. However, there was insufficient control over access to the cells, and appropriate privacy was not afforded to detainees being asked to disclose personal information. Children were detained for as short a time as possible, and there was suitable care for the needs of women. Staff were not well prepared for supporting those with disabilities. There was sufficient provision at Bishopsgate for religious needs.

2.9 Risk assessments were mainly clear and thorough, with constructive care plans. Risk management was careful and proportionate, responding to changing circumstances. Handovers at shift changes were often not thorough and did not ensure the passing on of relevant information to all incoming staff.

2.10 Care was taken to ensure that those being released were able to reach their homes safely, especially young and vulnerable people, but there was a reluctance to issue small cash sums for fares when that was likely to be helpful. There was relatively little use of handcuffs, and the reasons for use were recorded. There was no separate recording of uses of force to support monitoring and analysis in this area.

2.11 The cells at Bishopsgate were clean and in good condition – in contrast with the booking-in area and kitchen, which were shabby and presented a downbeat appearance. The cells at Snow Hill had some ingrained dirt and contained graffiti. A weekly checklist was used at Snow Hill but not at Bishopsgate. Showers were not sufficiently private, and there was little evidence of detainees regularly being offered one. Other facilities, such as food and drink, and clothing, were satisfactory but there were no proper exercise areas, there was limited access to reading materials and visits were never facilitated.

Individual rights

2.12 There was a high level of attention to the rights and dignity of those detained. The level of voluntary attendance at the custody suite was increasing and sergeants actively tested the need for detention before authorising it. Custody staff were ready to progress cases even at night, and solicitors were content with the way that staff facilitated their work, including giving detainees private telephone calls to legal advisers.

2.13 There was an effective appropriate adult (AA) scheme for juveniles and vulnerable adults. Detainees who could not speak English fluently were well supported with translated materials and the use of professional interpretation, both in person and by telephone. Those detained for

reasons connected with their immigration status were seen and dealt with promptly by UK Border Agency staff.

2.14 Up-to-date copies of the PACE codes of practice were available for detainees. Detention reviews took place at the right times, with variable levels of thoroughness. Court closing times were reasonable, and did not have any negative impact on detention in police custody. All procedures in relation to DNA and forensic samples were carried out correctly. Although correct information was given in leaflets about how to make complaints, in practice these guidelines were not followed.

Health care

2.15 Clinical governance arrangements, under a relatively new contract, appeared to work well within the provider's own structures but there was not effective communication or liaison by the provider with partner agencies or the agency commissioning the service. The clinical rooms were in poor condition and not properly equipped or maintained. Those needing to see a health care professional were able to see one quickly. Storage and control of medications fell short of the expected standard, and there was some unacceptable dispensing practice.

2.16 There was a good substance misuse service, which extended to juveniles and to those with alcohol-related problems. The service made suitable referrals to detainees' local services all over the UK. The mental health provision was reasonable but there was no diversion or liaison service operating from the suites, and there was insufficient clarity in the local NHS service's policy and practice on those detained under section 136 of the Mental Health Act.[3]

Main recommendation

2.17 **There should be systematic and clearly recorded quality assurance of custody records, linked to evidence from closed-circuit television, person escort records and staff handovers.**

National issues

2.18 **Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours.**[4]

[3] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

[4] Although the approach met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles.

3. Strategy

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

Strategic management

3.1 Strategic leadership for the custody function was provided by the assistant commissioner. At the senior management team (SMT) level there was an operations chief inspector who chaired the custody user group and line-managed a full-time custody manager (an inspector), who was visible in custody, although the lack of recording made it difficult to evidence the effectiveness of management oversight (see paragraph 3.5). The custody manager line-managed response team sergeants undertaking custody sergeant duties; these resources were provided by the duty inspector on a shift basis.

3.2 There was one designated full-time custody suite in the City of London, at Bishopsgate, providing a capacity of 15 cells. There was a stand-by facility at Snow Hill, which provided an additional seven cells and was used for planned events and operations.

3.3 Staffing within custody suites was good, and comprised response team sergeants, carrying out custody sergeant duties, supported by permanent police staff gaolers, who looked after the ongoing care and welfare of detainees. Cover within the staffing of custody units was provided by other sergeants from the operational teams, and police constables for the police staff gaolers.

3.4 There were no formal arrangements for dedicated custody sergeants, with sergeants generally carrying out custody duties on an ad hoc basis. The police staff gaolers, however, were full time in the role. Police staff gaolers were line-managed on a daily basis by the sergeants undertaking the custody role.

3.5 There was daily liaison between the custody manager and the operations chief inspector to discuss any custody issues. The operations chief inspector attended the weekly SMT meeting, where custody issues could be resolved, and chaired a quarterly custody user group (CUG) meeting. There was a good cross-section of attendance at the latter meeting, including custody practitioners, but not a representative from G4S, which provided health care services. It reported to the quarterly organisational learning forum. This forum was chaired by the assistant commissioner, who also chaired a monthly performance management group that included custody.

3.6 There was a comprehensive set of operating procedures within an overarching policy but parts of this were outdated; a revision was currently awaiting sign-off. There was evidence of some quality assurance of custody records having taken place in April 2012, and learning from this was fed into the training and development of staff, but there was no structured dip-sampling of custody records. Consequently, there was no systematic checking of custody records against the corresponding CCTV and person escort records, nor any monitoring of the quality of staff handovers by reference to the records of those in custody at the relevant time (see main recommendation 2.17).

3.7 There was a process for dealing with successful interventions. A form was generated from the computer system (Form 50) in custody and passed on to the custody manager. The custody manager assessed the level of investigation that was needed and referred to the Professional Standards Department if appropriate. The lessons learned from successful interventions informed staff training.

3.8 Independent Police Complaints Commission (IPCC) 'learning the lessons' information was available via a link on the dedicated custody web page of the force intranet. The custody manager drew staff's attention to custody-specific issues in this document. Most custody information was communicated to staff by the custody manager via email. The web page was not fully utilised to provide a central repository for staff to access information and they were unclear about what information they would receive and how to access it.

Recommendation

3.9 **G4S Forensic Medical Services should be part of the custody user group.**

Housekeeping points

3.10 City of London police should review the staffing arrangements for sergeants undertaking the custody role to ensure consistency and continuity in the custody manager role and consistency of line management for police staff gaolers.

3.11 Use of the dedicated custody web page should be developed to provide a central repository to enable staff to access information.

Partnerships

3.12 Partnership working was good, with the assistant commissioner sitting on the pan-London Criminal Justice Board (CJB), although this had not met for some time. The superintendent operational lead for the Criminal Justice Directorate attended the City of London Local CJB. Relationships with the Crown Prosecution Service and the courts were described as good, with close working relationships between the Head of Criminal Justice and other criminal justice partners.

3.13 The police committee of the City of London Corporation oversaw policing in the City, and an established ICV scheme provided scrutiny. ICVs and Police Committee members told us that they were admitted to the custody suites quickly and that staff were courteous and professional. The operations chief inspector regularly attended ICV panel meetings.

Learning and development

3.14 All sergeants performing custody duties and police staff gaolers had received training before going into custody. Annual mandatory training and custody refresher training was provided.

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 were respectful and polite to detainees, using their first names when appropriate. Detainees told us that they were treated well and that they felt assured that their rights and entitlements would be upheld. In our survey, more respondents than at comparator custody suites (75% against 34%) said that they had been treated well or very well. Detainees did not spend long in the holding rooms.

4.2 The booking-in area at Bishopsgate was of a reasonable size but there were no screens to separate the three booking-in terminals, so the levels of privacy were poor. The booking-in area at Snow Hill was small, with only one terminal. The suite was not in use at the time of the inspection. We observed detainees arriving at Bishopsgate being asked personal questions about their mental health in the hearing of other detainees being released, although one custody sergeant took a detainee into the holding room to deliver a caution in private.

4.3 There was a constant flow of non-custody staff through the custody suite, for legitimate reasons, and access to the suite was mostly well managed.

4.4 Custody staff were aware that young women detainees should be in the care of a female officer at all times. If there were none on duty, they would request a female officer to attend. Our analysis of 30 custody records showed that the two female detainees in the sample had been given the opportunity to speak with a female member of staff. The national strategy for police information systems (NSPIS) risk assessment prompted custody sergeants to ask female detainees if they might be pregnant.

4.5 There were no designated cells for female detainees or any detention rooms for juvenile detainees at Bishopsgate, although there were two detention rooms designated for juveniles at Snow Hill. Few juveniles were detained, and our custody record analysis showed a group of juveniles being detained for as short as time as possible. At Bishopsgate, custody sergeants used the cells closest to the booking-in area for detainees about whom they had concerns or who required frequent monitoring. We were told that young people were sometimes, subject to risk assessment, allowed to wait in the holding room with an AA. Custody sergeants were generally aware of safeguarding imperatives regarding young people and vulnerable adults, and had a list of agencies to refer to. All detainees were asked about dependency issues during the booking-in process.

4.6 Neither suite had adapted cells for older detainees or those with disabilities. One cell at Bishopsgate had a wide door that could accommodate detainees in wheelchairs but the call bell was too high. The bed plinths at both suites were at an appropriate height for older detainees and those with disabilities. There was a portable hearing loop in the booking-in area at both suites but staff at Bishopsgate did not know how to operate it.

4.7 The custody staff we spoke to were aware of the particular needs of transgender detainees when being searched and said that they would allow them to indicate a preference about the

gender of staff searching them. Staff had access to excellent standard operating procedures concerning, among other issues, the treatment of transgender detainees.

4.8 At Bishopsgate, there were two prayer boxes with items for Muslim observance, including a Qur'an and an ablution jug, which were stored and handled respectfully. There was also a Bible but no holy books for other religions. We observed a detainee being asked about his dietary and religious needs. Once he had disclosed that he was Muslim, the detention officer told him about the religious items, which he later used. At Snow Hill, the facilities for religious observance were inadequate; we could find only the Bible and no other items or holy books.

Recommendations

4.9 **Arrangements in booking-in areas should allow for private communication between detainees and staff.**

4.10 **There should be designated adapted cells that have a lowered call bell.**

4.11 **There should be a range of items at both suites to facilitate religious observance.**

Housekeeping point

4.12 All custody staff should know how to operate the hearing loop.

Safety

4.13 Custody sergeants told us that, owing to the transient nature of the local population, risk assessment was particularly important as they had no prior knowledge of most detainees. We observed custody sergeants assessing each detainee and recording decisions about observation levels. During booking in, they asked the questions specified on NSPIS, as well as supplementary questions about health and emotions, especially when there were indications of self-harm. In our custody record analysis, three detainees (10%) had had current or previous self-harm or suicide issues. A detainee who had disclosed a desire to self-harm had appropriately been placed on higher levels of observation. Risk assessments were clear and were reviewed and amended during detention, according to detainees' individual circumstances.

4.14 In all the records sampled, staff had implemented the care plan. Any detainee with a head injury or under the influence of alcohol was placed on rousing checks and staff knew how to use proper rousing to elicit responses. Custody sergeants told us that, to inform their ongoing risk assessment, they expected the gaolers to tell them how each detainee responded to rousing.

4.15 Custody sergeants at Bishopsgate told us that if a detainee was brought to the suite under the influence of alcohol and unable to stand, they would not authorise detention and would instruct officers to take the detainee to hospital. At Bishopsgate, all the cells were monitored by CCTV, with toilet areas appropriately obscured. All staff carried anti-ligature knives. There was an anti-ligature knife on each key bunch at Snow Hill, and a larger ligature cutter at the booking-in desk. Custody staff were aware of the IPCC 'learning the lessons' information and were conversant with procedures for reporting near misses and adverse incidents.

4.16 Staff handovers at Bishopsgate were unsatisfactory. They did not involve the whole team. We observed an outgoing custody sergeant superficially going through who was in the custody suite while another custody sergeant was releasing a detainee. Gaolers had their own separate handover, which was unsystematic and basic.

4.17 Pre-release risk assessments were conducted but their quality varied. In our custody record analysis, a pre-release risk assessment had been completed in all the records sampled, and there was evidence that any vulnerabilities had been addressed. We were told that staff sometimes contacted social services if they were concerned about vulnerable detainees on release. We observed one custody sergeant asking a detainee, during release, about his apparent low mood. Custody sergeants gave detainees being bailed clear reporting instructions to attend their local police stations, and printed maps for them. We were told that they prioritised transport home for older detainees, making sure that someone would be at home on their arrival. All detainees were asked how they would get home. However, even though one female detainee told the custody sergeant that she had no money to get home, the custody sergeant made no attempt to seek authorisation from an inspector to give her the bus fare. She said that she would have to ask people on the street for money and the custody sergeant responded that if she did that she might be arrested for begging.

4.18 Leaflets about homeless shelters and support agencies were available at the police station front desk, which was staffed 24 hours a day.

Recommendations

4.19 **All custody staff should be involved in the same shift handover; where possible, this should take place away from the booking-in area and be recorded.**

4.20 **Bus fares should be provided to bailed or released detainees who have no legitimate means of getting home.**

Housekeeping point

4.21 Detainees being released should be offered a leaflet about support agencies.

Use of force

4.22 None of the detainees we observed arriving at Bishopsgate were handcuffed. Some of the detainees we spoke to said that they had been handcuffed and that their cuffs had been removed on arrival at the custody suite. Custody sergeants asked arresting officers whether the detainees had been restrained; if they had been, officers were expected to justify the reason for this, and this was recorded on the custody record.

4.23 Custody staff described using de-escalation techniques with detainees who were not compliant. We were told that in some circumstances the tactical support group was asked to attend the suite and that their presence would usually de-escalate the situation. In the event that custody staff had to use force, they recorded it on a use of force form and in the custody record. However, there was no monitoring of use of force, so opportunities to review and learn from such incidents might be missed. All staff had been trained in approved personal safety techniques and received refresher training twice a year.

4.24 Staff told us that a decision to strip-search a detainee was part of the risk assessment and based on relevant intelligence. We saw no strip-searching taking place. The force did not collect data about strip searching.

Recommendation

4.25 **The City of London Police should collect and analyse data about use of force and strip-searching in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance.**

Good practice

4.26 *Arresting officers were expected to justify the use of handcuffs and this was recorded on the custody record.*

Physical conditions

4.27 The booking-in area at Bishopsgate was shabby and in a poor state of decoration, with ragged notices taped to the back wall. However, the cells were clean, well maintained and free from graffiti, with some, albeit limited, natural light, and the communal areas were spacious, clean and light. Cleaners attended the custody suite every day. Gaolers told us that they would clean up minor spills if the cleaners had already left the custody suite. An outside contractor could be contacted to deal with bodily fluid spillages. In our survey, more respondents than at comparator custody suites said that the cleanliness and temperature of the cells was good. At Snow Hill, the suite was superficially clean but there was much ingrained dirt on the floors and walls. There was graffiti on the cell doors and bed plinths. In one cell, the CCTV camera had been pelted with dirt that had not been cleaned off.

4.28 Custody staff at Bishopsgate checked the condition of the cells, cell call bells, lights and toilet flush before and after each occupancy, recording it on the custody record. We observed a gaoler checking the cells when he came on duty and consulting a custody sergeant about a potential ligature point, which appropriately resulted in the cell being taken out of use. We were told that sergeants undertook daily, and the custody manager weekly, health and safety checks but neither of these checks was recorded, although at Snow Hill a weekly checklist was in use. Quarterly health and safety checks were undertaken and recorded, and actions generated and actioned. We found no ligature points.

4.29 Access to cells keys was not well controlled. Custody sergeants told us that they would provide keys to any non-custody staff, provided that they were informed about the visit and the reason for it.

4.30 Detainees we spoke to at Bishopsgate told us that custody staff had explained the use of the cell call bell. In our survey, 42% of respondents, compared with 23% at other custody suites, said that staff had explained how to use the call bell. We saw gaolers responding promptly to call bells.

4.31 There was no fire evacuation box at either suite. At Bishopsgate, custody staff told us that they no longer had sufficient handcuffs for an evacuation. A desktop fire exercise had taken place in the previous year and there was a fire evacuation plan on the wall of the booking-in area. Custody sergeants and gaolers were conversant with the correct procedures in the event of a

fire and said that officers would be called to assist with evacuating the suite. Smoking was not permitted in the custody suite.

Recommendations

4.32 **All cells should be clean and free of graffiti.**

4.33 **Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised.**

4.34 **Regular fire evacuation drills should be carried out and recorded, with sufficient handcuffs available.**

Housekeeping point

4.35 Cell checks should be systematically recorded so that progress in addressing defects can be monitored effectively.

Detainee care

4.36 All cells at both suites contained a mattress and a pillow, but at Bishopsgate they were not routinely wiped down between uses. We found stocks of clean blankets at this custody suite and detainees we spoke to who had arrived during the early hours of the morning told us that they had been given blankets. There was toilet paper in the some of the cells and gaolers told us that they supplied it subject to risk assessment. There were no hand basins in the cells but there was one available in the communal area.

4.37 In our survey, none of the respondents said that they had been offered a shower. Our custody record analysis showed that two detainees had gone to court without being offered a shower, although it was recorded that one detainee who had been in custody for over 45 hours had used the 'washing facilities'. Although the shower at both suites was spacious and clean, neither afforded any privacy, as both lacked a door. Gaolers told us that detainees preferred to use the hand basin.

4.38 Toothbrushes, toothpaste, razors, combs and replacement underwear were available at both suites. Female detainees were not routinely told about or offered a feminine hygiene pack.

4.39 In our survey, 80% of respondents who had had their clothing removed, compared with 39% at other custody suites, said that they had been given a tracksuit. There was a good stock of replacement clothing at Bishopsgate, including paper suits, tracksuits and plimsolls. Custody staff told us that only immigration detainees who were being taken to immigration removal centres could have clothing brought in by family and friends. Stocks of replacement clothing at Snow Hill were minimal and unlikely to be sufficient if the suite was full.

4.40 Our custody record analysis showed that 17 detainees (57%) in our sample had been offered at least one meal while in custody. However, of the remaining detainees, all but three had been in custody for less than six hours. A selection of microwave meals was available, including halal and vegetarian options, as well as hot drinks. We saw detainees being offered meals and drinks regularly. In our survey, 26% of respondents who had been given food said that the quality had been good or very good, which was better than the 11% comparator. The

kitchens at both suites were cramped and untidy. The microwave at Snow Hill was dirty. All detainees were asked about dietary requirements when they were booked in.

4.41 There were no exercise yards, so detainees held over the weekend had no opportunity to go out in the fresh air. One custody sergeant at Bishopsgate told us that if a detainee was particularly agitated, he would permit him or her to go outside in the back yard, accompanied by an officer.

4.42 There was insufficient reading material available. At Bishopsgate, there was a box of magazines and a few books. Custody staff told us that they sometimes brought in free newspapers. During the inspection, one detainee who had been pacing the floor of his cell for some time was not offered anything to read. We asked if he could be given something to read and were told that he could make a request for this; however, none of the detainees we spoke to were aware that they could ask for reading materials. There was no reading material suitable for juveniles, in languages other than English or in easy-read format. In our custody record analysis, only five detainees (17%) had been given reading materials. We found no reading materials at Snow Hill.

4.43 Visits by detainees' relatives were not facilitated, even though there was a secure visits room at Bishopsgate that was used by detainees for legal consultations and telephone calls.

Recommendations

4.44 **All detainees held overnight, or who require one, should be offered a shower.**

4.45 **Adequate stocks of replacement clothing should be held at both suites.**

4.46 **Suitable facilities should be provided for detainees to have exercise in the open air.**

4.47 **A range of reading materials should be offered, including books and magazines suitable for young people and non-English speakers.**

4.48 **Visits should be facilitated for, in particular, vulnerable young people or detainees held for long periods.**

Housekeeping points

4.49 Mattresses should always be wiped down with an antibacterial cleaner between uses.

4.50 Female detainees should routinely be offered feminine hygiene packs.

4.51 Food preparation areas and equipment should be kept clean and hygienic at all times.

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 saw only a few detainees being booked in; most were answering bail. We observed custody sergeants checking the circumstances of the offence and arrest to determine if detention was appropriate. Most sergeants could recall only a few occasions when they had refused to detain once an arrest had been made. Nevertheless, there was a focus on the use of voluntary attendance for interview as an alternative to arrest for selected offences. In May 2012, there had been 30 such voluntary interviews at Bishopsgate. We saw several officers seeking advice from custody officers before arranging interviews with suspects, to determine if specific offences and circumstances warranted arrest and detention, and appropriate advice was given.

5.2 Solicitors we spoke to told us that their clients had been detained for an appropriate length of time and that custody sergeants did their best to minimise the length of time spent in custody. We did not observe any cases where detention appeared to be unnecessarily prolonged. We were assured that, whenever possible, detainees would be interviewed and processed during the night if this was appropriate and that there was no 'bedding down' culture. In our custody record analysis, only one detainee had been held for more than 24 hours. Detainees were able to make telephone calls to a legal adviser in private, and staff facilitated solicitors' work appropriately.

5.3 Data supplied by the force showed that in the current year, 177 immigration detainees had been held in custody, with an average detention time of 16.5 hours. Custody staff reported good relationships with the UK Border Agency, and the length of time that immigration detainees spent in police custody was said to be reducing. A professional telephone interpreting service, used with two-handset telephones, was available at the booking-in desks. Staff described the interpreting service as very good.

5.4 Information about rights and entitlements was available, in a suitable range of languages, both online for downloading and printing, and on laminated cards that could be photocopied. The information was also available in Braille but none was available in a pictorial or easy-read format for detainees with limited literacy.

5.5 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]

5.6 The force adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless they were otherwise deemed vulnerable (see recommendation 2.18). Family members or friends were usually the first consideration when an AA was required for juveniles or vulnerable adults. When this was

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

not possible, staff had access to either a recognised local AA service or staff from the Youth Offending Team. Custody staff generally felt well served by those services.

5.7 Custody sergeants told us that, when necessary, they contacted social services for secure accommodation beds to prevent juveniles from being held in police custody overnight, but were always informed that no beds were available. They did not consider the use of non-secure beds for vulnerable juveniles who did not require secure accommodation but somewhere safe to stay, but they gave examples of cases where they had bailed young people to avoid holding them in custody. In our custody record sample, there were seven young people aged under 17 who were part of a group arrested for alleged damage to public property. They had all been held for less than five hours, provided with an AA and released into their care.

Recommendations

5.8 **Information about detainees' rights and entitlements should always be available in formats that meet the needs of detainees whose literacy is limited.**

5.9 **The City of London Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court.**

Rights relating to PACE

5.10 Although, in our survey, only 36% of respondents said that they had been informed of their rights under PACE (which was worse than the comparator of 52%), we saw staff providing all detainees during booking in with an excellent booklet summarising their rights and entitlements. Detainees were told that they could consult the PACE codes of practice, up-to-date copies of which were readily available at both suites. Staff explained detainees' rights and entitlements carefully, including the right to free legal representation. Those who declined the services of a solicitor were asked the reasons why, which were recorded in the custody record, and they were reminded that they could change their mind later if they wished. Our custody record analysis indicated that 19 detainees (63%) had either seen or spoken to a solicitor or had been reminded of their right to advice during a review.

5.11 The duty solicitor scheme was advertised in a multi-language poster displayed behind the custody desk, although it was in a poor condition and sited too far away to be seen easily by detainees during booking in. Solicitors we spoke to told us that custody staff were helpful and that they could receive a copy of a detainee's custody record on request.

5.12 On booking in, detainees were told that they could inform someone of their arrest. We saw staff contacting people promptly, although the custody record analysis indicated that the nominated contact had been informed in only 37% of cases. In 47% of cases, there was no evidence that anyone had been contacted; however, in many instances the detainee's preference had not been clearly noted in the custody record.

5.13 The custody record analysis showed that inspector reviews were held according to PACE requirements. When reviews had been conducted while the detainee was asleep, there was usually evidence that the detainee had been informed of the review on waking. In every instance, a note had been made that the detainee should be told of the review and reminded of their rights. Detainees were not interviewed while under the influence of drugs or alcohol.

Reviews observed during the inspection varied from the very brief to the thorough – in the latter cases, good care was shown for the detainee's wellbeing.

5.14 There was an effective process for the prompt collection of DNA samples.

5.15 Arrangements for getting detainees to court on time appeared to be efficient. Court cut-off times were approximately 3pm on weekdays and noon on Saturdays.

Housekeeping point

5.16 Posters promoting free legal advice should be in good condition and displayed where they are easily visible.

Rights relating to treatment

5.17 Detainees were not routinely told how to make a complaint about their treatment, although the complaints procedure was described in the booklet issued to detainees on arrival. There was a clear expectation from the force that complaints would be taken while the detainees were still in custody; however, staff told us that, providing that the complaint was not of a serious nature, they would advise complainants to attend the front desk of the police station on release. Information about complaints was collected but there was no breakdown of those that related to custody, so there was no analysis of trends and themes.

Recommendation

5.18 **Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody.**

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 G4S Forensic Medical Services (G4SFMS) had recently been contracted by City of London Police to provide primary care services to detainees. They were not part of the custody user group and had minimal contact with the substance misuse service providers or East London Mental Health Trust. The custody manager met representatives from G4SFMS regularly but the contract lacked penalty clauses for poor performance. The force was about to prepare for the move towards the NHS commissioning of offender health services.

6.2 A health care professional (HCP) was allocated to the Bishopsgate custody suite at all times. During the day, they were required to be on site but at night they could be 'on call', although no more than one hour's journey from the custody suite. A forensic medical examiner (FME) could be called in if required, and he or she had similar response times.

6.3 G4SFMS had reasonable clinical governance structures in relation to the management and training of staff. There were relevant e-learning modules for staff to complete and the area manager made regular visits to meet staff at the suite.

6.4 Neither of the clinical rooms was fit for purpose or met infection control standards, and there was no clear ownership of the rooms. The room at Bishopsgate was untidy, had too many fabric-covered chairs and no paper roll for hand washing or to cover the couch, and there was thick dust on the tops of the wall cupboards. The pharmacy reference book was out of date and the sharps bin was not signed or dated. There was a mobile privacy screen that could be used if required. The room at Snow Hill resembled a store room, with four clinical waste bins and seven sharps bins on the floor, as well as a box of equipment from G4SFMS under the couch. There were out-of-date forensic examination kits in both rooms.

6.5 There was an automated external defibrillator in each suite but no oxygen or suction. We were told that they were checked weekly but there were no documents to support this. Staff had been trained in resuscitation.

Recommendation

6.6 **All clinical rooms should be fit for purpose and meet infection control guidelines.**

Housekeeping point

6.7 All resuscitation equipment should be checked regularly, and such checks should be documented.

Patient care

6.8 In our analysis of custody records, 10 detainees (30%) had been seen by an HCP. The average wait had been 15 minutes and the longest wait 35 minutes. We did not see any HCP consultations but these results concurred with anecdotal information from custody staff. Staff told us that they informed the custody manager if there were delays.

6.9 Detainees did not have a choice as to the gender of the attending FME but custody staff told us that they would organise a chaperone if required. There was a two-way telephone in the clinical room at Bishopsgate which was used if a telephone interpreting service was required.

6.10 HCPs used NSPIS to record clinical findings, as well as G4SFMS proformas for contemporaneous records. The latter were stored in line with Caldicott guidelines.[6]

6.11 There were concerns about the management of medications. 'Seized medications' were not held securely and we found some in a bag dated March 2012. We were not able to check the scheduled drugs at Snow Hill but at Bishopsgate we noted that two diazepam tablets were missing. We brought this to the attention of the HCP and were subsequently told that the necessary steps had been taken to report this and that an investigation had revealed a documentation error by an HCP. HCPs worked to patient group directions or contacted the FME for a verbal prescription if required. HCPs dispensed detainees' medications into plastic bags, which was secondary dispensing. The bags were put into individual locked cupboards in the clinical room; the administration time was flagged on NSPIS and the medications were then given either by a gaoler or the HCP. We found a full pack of antibiotics and a discharge letter from the local accident and emergency department in one of the lockers after the detainee concerned had left the custody suite.

6.12 Some detainees were not able to continue their medications if these were controlled drugs, as there was a reluctance to prescribe such medications. In our analysis of custody records, six detainees (20%) had reported being on medication on arrival in custody. Of these, three had been seen by an HCP and prescribed ongoing medication, although not necessarily their usual prescribed medications. One, a diabetic, had been well cared for, with the HCP advising the custody staff throughout his stay.

Recommendations

6.13 **All medications should be stored safely and securely at all times.**

6.14 **Secondary dispensing should not be routine.**

Substance use

6.15 Substance Misuse Partnerships, employees of the Corporation of London, provided an arrest referral service to the police and courts in the City of London. There was a worker present at Bishopsgate from 8am until 10pm, from Monday to Friday, who saw detainees (including those under 18) with either drug or alcohol issues. They were able to provide harm minimisation and brief intervention sessions to those they saw but were only funded to provide further services

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

to City of London residents. Most of their time was therefore spent referring clients to other substance misuse services in their home area.

6.16 In our survey, 32% of respondents said that they had a drug or alcohol problem, against a comparator of 53%. In our custody record analysis, all detainees had been offered the services of a substance misuse worker but all had declined. Figures provided by the team showed that in 2011/12 the arrest referral/drugs workers had carried out 324 assessments. Ninety-two per cent of these had been carried out in the police stations as a result of a positive drug test and the rest had been voluntary referrals.

6.17 Needle exchange was not available in custody.

Housekeeping point

6.18 Needle exchange should be available to detainees leaving custody if required.

Mental health

6.19 There was no mental health liaison or diversion scheme. If a mental health assessment was required while a detainee was in custody, the FME contacted the Corporation of London social services team during office hours or Hackney social services emergency duty team, which covered out of hours. Both teams said that they would be able to provide a team to undertake an assessment within a couple of hours of the request, providing that a section 12-approved doctor was available.

6.20 Detainees arrested under section 136 of the Mental Health Act 1983 were taken to the section 136 suite provided by the East London NHS Foundation Trust (ELFT). Management data on the use of this suite was kept by ELFT. Between 1 April and 18 June 2012, five of the 22 patients (4.4%) admitted to the section 136 suite had been taken there by City of London Police, and 14% of those taken there in the previous year had later been admitted to the unit.

6.21 Staff at ELFT described their partnership with City of London Police as good. There were regular section 136 liaison meetings, chaired by ELFT, which officers from City of London Police attended. There was no evidence that representatives of the City of London Corporation attended these meetings. Minutes of the meetings showed that relevant matters were discussed, although there was confusion about where some detainees should be taken, and there were some issues relating to communication between the police and the unit before a detainee's arrival which needed clarification. The section 136 protocol had not been reviewed since February 2009.

Recommendation

6.22 **There should be a mental health liaison and/or diversion scheme to enable detainees with mental health problems to be identified and diverted in to appropriate mental health services as required.**

Housekeeping point

6.23 The section 136 protocol should be reviewed to ensure that it is in line with current policy.

7. Summary of recommendations

Main recommendation

7.1 There should be systematic and clearly recorded quality assurance of custody records, linked to evidence from closed-circuit television, person escort records and staff handovers. (2.17)

National issues

7.2 Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours. (2.18)

Recommendations

Strategy

7.3 G4S Forensic Medical Services should be part of the custody user group. (3.9)

Treatment and conditions

7.4 Arrangements in booking-in areas should allow for private communication between detainees and staff. (4.9)

7.5 There should be designated adapted cells that have a lowered call bell. (4.10)

7.6 There should be a range of items at both suites to facilitate religious observance. (4.11)

7.7 All custody staff should be involved in the same shift handover; where possible, this should take place away from the booking-in area and be recorded. (4.19)

7.8 Bus fares should be provided to bailed or released detainees who have no legitimate means of getting home. (4.20)

7.9 The City of London Police should collect and analyse data about use of force and strip-searching in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance. (4.25)

7.10 All cells should be clean and free of graffiti. (4.32)

7.11 Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.33)

7.12 Regular fire evacuation drills should be carried out and recorded, with sufficient handcuffs available. (4.34)

7.13 All detainees held overnight, or who require one, should be offered a shower. (4.44)

7.14 Adequate stocks of replacement clothing should be held at both suites. (4.45)

7.15 Suitable facilities should be provided for detainees to have exercise in the open air. (4.46)

7.16 A range of reading materials should be offered, including books and magazines suitable for young people and non-English speakers. (4.47)

7.17 Visits should be facilitated for, in particular, vulnerable young people or detainees held for long periods. (4.48)

Individual rights

7.18 Information about detainees' rights and entitlements should always be available in formats that meet the needs of detainees whose literacy is limited. (5.8)

7.19 The City of London Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.9)

7.20 Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody. (5.18)

Health care

7.21 All clinical rooms should be fit for purpose and meet infection control guidelines. (6.6)

7.22 All medications should be stored safely and securely at all times. (6.13)

7.23 Secondary dispensing should not be routine. (6.14)

7.24 There should be a mental health liaison and/or diversion scheme to enable detainees with mental health problems to be identified and diverted in to appropriate mental health services as required. (6.22)

Housekeeping points

Strategy

7.25 City of London police should review the staffing arrangements for sergeants undertaking the custody role to ensure consistency and continuity in the custody manager role and consistency of line management for police staff gaolers. (3.10)

7.26 Use of the dedicated custody web page should be developed to provide a central repository to enable staff to access information. (3.11)

Treatment and conditions

7.27 All custody staff should know how to operate the hearing loop. (4.12)

7.28 Detainees being released should be offered a leaflet about support agencies. (4.21)

7.29 Cell checks should be systematically recorded so that progress in addressing defects can be monitored effectively. (4.35)

7.30 Mattresses should always be wiped down with an antibacterial cleaner between uses. (4.49)

7.31 Female detainees should routinely be offered feminine hygiene packs. (4.50)

7.32 Food preparation areas and equipment should be kept clean and hygienic at all times. (4.51)

Individual rights

7.33 Posters promoting free legal advice should be in good condition and displayed where they are easily visible. (5.16)

Health care

7.34 All resuscitation equipment should be checked regularly, and such checks should be documented. (6.7)

7.35 Needle exchange should be available to detainees leaving custody if required. (6.18)

7.36 The section 136 protocol should be reviewed to ensure that it is in line with current policy. (6.23)

Good practice

Treatment and conditions

7.37 Arresting officers were expected to justify the use of handcuffs and this was recorded on the custody record. (4.26)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Gary Boughen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Peter Dunn	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Roger James	CQC
Olayinka Macauley	HMIP researcher
Alice Reid	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

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

Choosing the sample size

The survey was conducted on 12 June 2012 at HMP Wandsworth. A list of potential respondents to have passed through Bishopsgate or Snow Hill police stations was created from a list of all those who had arrived from City of London Magistrates' court within the previous two months.[7]

Selecting the sample

Due to insufficient numbers in the prison from this area, only 26 respondents were approached. Two respondents reported being held in police stations outside of the City of London and five could speak no English, so it was impossible to determine the police station that they had been held in. On the day, the questionnaire was offered to 19 eligible respondents. Two people refused to complete the survey. Seventeen respondents returned a completed questionnaire. All of those sampled had been in custody within the previous three months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, one respondent was interviewed.

Methodology

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

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

- 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.

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

Response rates

In total, 17 (100%) respondents completed and returned their questionnaires.

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 56 police areas since April 2008.

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

Summary

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

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

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

Police custody survey

Section 1: About you

Q2 Which police station were you last held at?

Bishopsgate – 17

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	6 (35%)
17-21 years	1 (6%)	*50-59 years*	0 (0%)
22-29 years	4 (24%)	*60 years or older*	0 (0%)
30-39 years	6 (35%)		

Q4 Are you:

Male	17 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	4 (24%)
White - Irish	0 (0%)
White - other	2 (12%)
Black or black British - Caribbean	2 (12%)
Black or black British - African	5 (29%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	1 (6%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	2 (12%)
Mixed heritage - white and black Caribbean	1 (6%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

Q6 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?

Yes	9 (53%)
No	8 (47%)

Q7 What, if any, is your religion?

None	1 (6%)
Church of England	4 (25%)
Catholic	3 (19%)
Protestant	1 (6%)

	Other Christian denomination	4 (25%)
	Buddhist	0 (0%)
	Hindu	3 (19%)
	Jewish	0 (0%)
	Muslim	0 (0%)
	Sikh	0 (0%)

Q8 How would you describe your sexual orientation?

	Straight/heterosexual	16 (94%)
	Gay/lesbian/homosexual	0 (0%)
	Bisexual	1 (6%)

Q9 Do you consider yourself to have a disability?

	Yes	1 (6%)
	No	16 (94%)

Q10 Have you ever been held in police custody before?

	Yes	13 (76%)
	No	4 (24%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?

	Less than 24 hours	7 (41%)
	More than 24 hours, but less than 48 hours (2 days)	8 (47%)
	More than 48 hours (2 days), but less than 72 hours (3 days)	1 (6%)
	72 hours (3 days) or more	1 (6%)

Q12 Were you told your rights when you first arrived there?

	Yes	14 (82%)
	No	1 (6%)
	Don't know/can't remember	2 (12%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?

	Yes	6 (35%)
	No	7 (41%)
	I don't know what this is/I don't remember	4 (24%)

Q14 If your clothes were taken away, what were you offered instead?

	My clothes were not taken	12 (71%)
	I was offered a tracksuit to wear	4 (24%)
	I was offered an evidence/paper suit to wear	0 (0%)
	*I was **only** offered a blanket*	1 (6%)
	Nothing	0 (0%)

Q15 Could you use a toilet when you needed to?

	Yes	16 (94%)
	No	1 (6%)
	Don't know	0 (0%)

Q16 **If you used the toilet there, was toilet paper provided?**

Yes	12 (71%)
No	5 (29%)

Q17 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	9 (53%)	4 (24%)	4 (24%)
Ventilation/air quality	4 (27%)	6 (40%)	5 (33%)
Temperature	5 (36%)	5 (36%)	4 (29%)
Lighting	8 (53%)	4 (27%)	3 (20%)

Q18 **Was there any graffiti in your cell when you arrived?**

Yes	7 (47%)
No	8 (53%)

Q19 **Did staff explain to you the correct use of the cell bell?**

Yes	7 (41%)
No	10 (59%)

Q20 **Were you held overnight?**

Yes	16 (94%)
No	1 (6%)

Q21 **If you were held overnight, which items of bedding were you given? (Please tick all that apply to you.)**

Not held overnight	1 (6%)
Pillow	6 (35%)
Blanket	15 (88%)
Nothing	1 (6%)

Q22 **If you were given items of bedding, were these clean?**

Not held overnight/did not get any bedding	2 (13%)
Yes	10 (63%)
No	4 (25%)

Q23 **Were you offered a shower at the police station?**

Yes	0 (0%)
No	17 (100%)

Q24 **Were you offered any period of outside exercise while there?**

Yes	0 (0%)
No	17 (100%)

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	15 (88%)	2 (12%)
Drink?	15 (100%)	0 (0%)

Q26 **What was the food/drink like in the police custody suite?**

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	4 (24%)	7 (41%)	2 (12%)	3 (18%)	1 (6%)

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

I did not have any food or drink	1 (6%)
Yes	7 (41%)
No	9 (53%)

Q28 **If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply to you.)**

I do not smoke	8 (50%)
I was allowed to smoke	0 (0%)
I was offered a nicotine substitute	0 (0%)
I was not offered anything to cope with not smoking	8 (50%)

Q29 **Were you offered anything to read?**

Yes	3 (20%)
No	12 (80%)

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

Yes	10 (63%)
No	3 (19%)
I don't know	1 (6%)
I didn't want to inform anyone	2 (13%)

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

Yes	13 (81%)
No	3 (19%)

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

My telephone call was not denied	14 (88%)
Yes	0 (0%)
No	2 (13%)

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

	Yes	*No*
Who was taking care of your children	1 (6%)	15 (94%)
Contacting your partner, relative or friend	7 (47%)	8 (53%)
Contacting your employer	1 (7%)	13 (93%)
Where you were going once released	3 (23%)	10 (77%)

Q34 **Were you offered free legal advice?**

Yes	15 (94%)
No	1 (6%)

Q35 **Did you accept the offer of free legal advice?**

Was not offered free legal advice	1 (7%)
Yes	10 (67%)
No	4 (27%)

Q36 Were you interviewed by police about your case?

Yes	15 (94%)
No	1 (6%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	2 (13%)
Yes	12 (75%)
No	2 (13%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	6 (40%)
Yes	4 (27%)
No	5 (33%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	8 (50%)
Yes	2 (13%)
No	6 (38%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	13 (81%)
No	3 (19%)

Q42 Did a member of staff victimise (insulted or assaulted) you there?

Yes	1 (6%)
No	15 (94%)

Q43 If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	15 (94%)	*Because of your crime*	1 (6%)
Insulting remarks (about you, your family or friends)	1 (6%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	1 (6%)	*Because you have a disability*	1 (6%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	1 (6%)		

Q44 Were your handcuffs removed on arrival at the police station?

Yes	14 (88%)
No	2 (13%)
I wasn't handcuffed	0 (0%)

Q45 Were you restrained whilst in the police custody suite?

Yes	4 (25%)
No	12 (75%)

Q46 **Were you injured while in police custody, in a way that was not your fault?**

Yes	3 (19%)
No	13 (81%)

Q47 **Were you told how to make a complaint about your treatment if you needed to?**

Yes	2 (14%)
No	12 (86%)

Q48 **How were you treated by staff in the police custody suite?**

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
2 (13%)	10 (63%)	2 (13%)	2 (13%)	0 (0%)	0 (0%)

Section 4: Health care

Q50 **Did someone explain your entitlements to see a health care professional if you needed to?**

Yes	8 (53%)
No	7 (47%)
Don't know	0 (0%)

Q51 **Were you seen by the following health care professionals during your time there?**

	Yes	*No*
Doctor	1 (8%)	11 (92%)
Nurse	3 (21%)	11 (79%)
Paramedic	1 (8%)	11 (92%)

Q52 **Were you able to see a health care professional of your own gender?**

Yes	5 (33%)
No	5 (33%)
Don't know	5 (33%)

Q53 **Did you need to take any prescribed medication when you were in police custody?**

Yes	6 (38%)
No	10 (63%)

Q54 **Were you able to continue taking your prescribed medication while there?**

Not taking medication	10 (63%)
Yes	1 (6%)
No	5 (31%)

Q55 **Did you have any drug or alcohol problems?**

Yes	5 (31%)
No	11 (69%)

Q56 **Did you see, or were you offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems	11 (69%)
Yes	3 (19%)
No	2 (13%)

Q57 **Were you offered relief or medication for your immediate withdrawal symptoms?**

I didn't have any drug/alcohol problems	11 (69%)
Yes	1 (6%)
No	4 (25%)

Q58 **Please rate the quality of your health care while in police custody:**

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
10 (67%)	0 (0%)	3 (20%)	2 (13%)	0 (0%)	0 (0%)

Q59 **Did you have any specific <u>physical</u> health care needs?**

Yes	3 (19%)
No	13 (81%)

Q60 **Did you have any specific <u>mental</u> health care needs?**

Yes	2 (13%)
No	14 (88%)

Q61 **If you had any mental health care needs, were you seen by a mental health nurse/ psychiatrist?**

I didn't have any mental health care needs	14 (88%)
Yes	0 (0%)
No	2 (13%)

Prisoner survey responses for City of London Police 2012

Prisoner survey responses (missing data have 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

		2012 City of London	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage 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		17	2059
SECTION 1: General information			
3	Are you under 21 years of age?	**6%**	**10%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**64%**	**29%**
6	Are you a foreign national?	**52%**	**15%**
7	Are you Muslim?	**0%**	**10%**
8	Are you homosexual/gay or bisexual?	**6%**	**2%**
9	Do you consider yourself to have a disability?	**6%**	**20%**
10	Have you been in police custody before?	**76%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**58%**	**68%**
12	Were you told your rights when you first arrived?	**82%**	**81%**
13	Were you told about PACE?	**36%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**80%**	**39%**
15	Could you use a toilet when you needed to?	**94%**	**91%**
16	If you used the toilet, was toilet paper provided?	**70%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**52%**	**34%**
17b	Ventilation/air quality?	**27%**	**23%**
17c	Temperature?	**37%**	**16%**
17d	Lighting?	**53%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**47%**	**54%**
19	Did staff explain the correct use of the cell bell?	**42%**	**23%**
20	Were you held overnight?	**94%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**94%**	**84%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**71%**	**62%**
23	Were you offered a shower?	**0%**	**9%**
24	Were you offered a period of outside exercise?	**0%**	**6%**
25a	Were you offered anything to eat?	**88%**	**81%**
25b	Were you offered anything to drink?	**100%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**26%**	**11%**
27	Was the food/drink you received suitable for your dietary requirements?	**45%**	**44%**

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For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	0%	7%
29	Were you offered anything to read?	21%	14%
30	Was someone informed of your arrest?	62%	43%
31	Were you offered a free telephone call?	81%	50%
If you were denied a free telephone call:			
32	Was a reason given?	0%	15%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	6%	14%
33b	Contacting your partner, relative or friend?	47%	52%
33c	Contacting your employer?	7%	19%
33d	Where you were going once released?	24%	31%
34	Were you offered free legal advice?	94%	89%
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	71%	69%
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	85%	80%
38	Was an appropriate adult present when you were interviewed?	44%	28%
39	Was an interpreter present when you were interviewed?	25%	13%
SECTION 3: Safety			
41	Did you feel unsafe?	19%	38%
42	Has another detainee or a member of staff victimised you?	6%	33%
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	6%	16%
43b	Physical abuse (being hit, kicked or assaulted)	6%	10%
43c	Sexual abuse	0%	3%
43d	Your race or ethnic origin	0%	3%
43e	Drugs	6%	9%
43f	Because of your crime	6%	12%
43g	Because of your sexuality	0%	1%
43h	Because you have a disability	6%	2%
43i	Because of your religion/religious beliefs	0%	2%
43j	Because you are from a different part of the country than others	0%	4%
44	Were your handcuffs removed on arrival at the police station?	87%	73%
45	Were you restrained whilst in the police custody suite?	26%	19%
46	Were you injured whilst in police custody, in a way that was not your fault?	19%	23%
47	Were you told how to make a complaint about your treatment?	15%	13%
48	Were you treated well/very well by staff in the police custody suite?	75%	34%

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SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	**53%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**9%**	**44%**
51b	Nurse	**22%**	**20%**
	Percentage seen by either a doctor or a nurse	**27%**	**51%**
51c	Paramedic	**9%**	**4%**
52	Were you able to see a health care professional of your own gender?	**34%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**38%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**17%**	**34%**
55	Did you have any drug or alcohol problems?	**32%**	**53%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**60%**	**43%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**20%**	**25%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**60%**	**30%**
59	Did you have any specific physical health care needs?	**19%**	**32%**
60	Did you have any specific mental health care needs?	**13%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	**15%**