Report on an inspection visit to police custody suites in the Metropolitan Police Service Borough of Croydon

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by

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1. Introduction

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

The inspection looked at the custody suites in Croydon and South Norwood, serving the London Borough of Croydon within the Metropolitan Police Service (MPS). Strategic oversight of the suites was provided centrally by the MPS Criminal Justice Directorate within the Territorial Policing department, which seeks to ensure consistency in custody provision across all London boroughs. The Metropolitan Police Authority (MPA) has responsibility for the estate and manages an active independent custody visitors scheme.

The borough commander was committed to developing custody provision for the borough, but some line management arrangements were confusing and few staff were dedicated to the role or had sufficient training. There was some good partnership working. As we have found elsewhere, there was a lack of appropriate monitoring of the use of force, both locally and London-wide.

Both suites were old, although in relatively good order, and there were advanced plans to replace them with a single new facility. Interactions with detainees were generally appropriate but there was limited attention to diversity and particular vulnerabilities. The booking-in arrangements allowed only limited privacy. Management of health and safety issues was satisfactory. Some basic hygiene needs were only provided when requested and not as a matter of course.

An appropriate balance was maintained between progressing cases and the rights of individuals, and the Police and Criminal Evidence Act (PACE) was rigorously adhered to. Legal advice was readily available. Juveniles and vulnerable adults were well served by an appropriate adult scheme during the day, but the lack of a night-time service or local authority PACE beds led to some juveniles being unnecessarily detained overnight. Immigration detainees were generally moved on quickly. Arrangements for managing DNA and forensic samples were good but complaint procedures were confused.

Healthcare provision was good, supported by effective clinical governance and robust medicines management. Nurses provided a good service, but the attendance of forensic medical examiners was sometimes subject to delay. Substance misuse services were good. While mental health diversion services were limited, custody was rarely used as a place of safety under the Mental Health Act.

Overall, custody provision in Croydon was generally sound. This report sets out a small number of recommendations that we hope will assist the MPS and MPA to improve the facilities further. We expect our findings to be considered in the wider context of priorities and

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

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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April 2011

2. Background and key findings

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

2.2 The Metropolitan Police Service (MPS) has 74 custody suites designated under PACE 1984 for the reception of detainees. Twenty are 'overflow custody suites' used for various operational matters, such as charging centres for football matches and operational demands over and above custody core business. They are also used as fallback suites when 24-hour ones are closed for short periods for maintenance work. One suite is used for when Operation Safeguard (overflow from prisons) is in operation. The remaining 53 custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.

2.3 This announced inspection was conducted at the Croydon and South Norwood custody suites in the London Borough of Croydon. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites. A survey of prisoners at HMP High Down who had formerly been detained in the suites was conducted by HM Inspectorate of Prisons researchers and HM Inspectorate of Constabulary inspectors (see Appendix II).[3]

2.4 Croydon custody suite had 14 cells and South Norwood 11 and they were open 24 hours a day. In the year to January 2011, Croydon custody had received 6,989 detainees and South Norwood 4,499, and 313 immigration detainees had been held across both suites in the same period.

2.5 Comments in this report refer to all suites, unless specifically stated otherwise.

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

[3] **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*.)

Strategic overview

2.6 The MPS Criminal Justice Directorate within the Territorial Policing department had strategic oversight of custody in all boroughs in London. Standard operating procedures (SOPs) were issued to boroughs and aimed to assist in the delivery of a consistent service in custody. The Metropolitan Police Authority (MPA) had responsibility for the custody estate and the independent custody visitors (ICV) scheme. The local ICV scheme was active and the borough was responsive to it. There were advanced plans to replace the two aging custody suites with a new 40-cell facility.

2.7 The borough commander was committed to developing custody provision in the borough. Some line management arrangements were confusing. Most staff were not permanent and there was a heavy reliance on police constables with little training in custody. Staff worked 12-hour shifts, although there were plans to change this. Dip sampling of custody records was undertaken, but some of this work had only recently been introduced.

2.8 There were strong partnerships in place, with a particular focus on making links with agencies dealing with young people. Learning the lessons information was shared with custody staff. Similar to elsewhere in the MPS, use of force was not monitored effectively.

Treatment and conditions

2.9 Staff interaction with detainees was generally respectful, although we observed exceptions. Awareness of diversity areas needed to be improved, although some staff were more aware of these issues. There were some privacy problems. Professional interpreting services were used when needed.

2.10 Risk assessments were carried out when detainees arrived in custody but their quality varied greatly. There was a cautious approach to risk management. Staff were aware of the need to rouse detainees under the influence of drugs or drink when necessary. There were staff handovers between shifts but they needed to be improved.

2.11 Both custody suites were old but there were very few physical safety problems. Cells and other detainee areas were generally clean and we saw little graffiti. Health and safety arrangements were reasonable, although some staff were not aware of fire evacuation procedures. Detainees were told how to use cell call bells, and these were responded to promptly.

2.12 Detainees were given clean mattresses, pillows and blankets. Showers were rarely facilitated. Toilets in cells covered by CCTV were obscured, but detainees had to request toilet paper. In some cases, detainees were given paper suits when their clothes were removed. The food and drinks provided were adequate. There were limited reading materials for detainees, and neither custody suite had adequate facilities for outside exercise.

Individual rights

2.13 We found a positive approach to balancing the priorities of progressing cases with the rights of individuals, but there was little focus on alternatives to custody. Detainees were offered a copy of PACE and comprehensive leaflets in a range of languages. We saw no breaches of PACE.

2.14 Legal assistance was offered and freely available. Staff made calls to notify someone of the detainee's arrest, and detainees were routinely asked if they had any dependency obligations. Children were not held in custody under section 46 of the Children Act 1989, but no PACE place of safety bed for juveniles were available in the borough.

2.15 Immigration detainees were usually moved on quickly, although there were exceptions. Relatives or friends were usually called upon to act as appropriate adults for juveniles and vulnerable adult detainees. When this was not possible or appropriate, there was a good appropriate adults service during the working day, but not out of hours.

2.16 The management of DNA and forensics, and cut-off times for courts, were good. Detainees were not routinely told how to make a complaint, and the arrangements for taking complaints were confused. The virtual court pilot had caused significant difficulties. Pre-release risk assessments were completed but usually meant little more than issuing a leaflet.

Health care

2.17 Primary health services were very good. Clinical governance arrangements were well developed and medicines management robust. Police staff made efforts to collect medications from detainees' home addresses. Resuscitation equipment was available to custody staff who were trained in its use, but some equipment was missing. Infection control arrangements in medical rooms needed to be improved.

2.18 We observed nurses providing some very good care to detainees, but there were delays in the arrival of forensic medical examiners when called. There were problems with providing symptomatic relief to detainees who required it.

2.19 Substance misuse services were good. Mental health diversion was limited but few detainees were held under Section 136 of the Mental Health Act 1983. [4]

Main recommendations

2.20 Staff should ensure that detainees have the opportunity during the booking-in process to outline any concerns or areas of vulnerability.

2.21 Pre-release risk assessment of detainees should consider all known risk factors, and staff should take appropriate action to ameliorate them when needed.

[4] 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.

3. Strategy

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

3.1 The Metropolitan Police Service (MPS) had a custody directorate led by a commander within territorial policing headquarters. A superintendent was responsible for day-to-day management of the custody directorate. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and accountability therefore rested with a chief superintendent. Each borough had a lead member from the Metropolitan Police Authority (MPA) but there was no defined MPA lead for custody. However, an MPA official managed the Independent Custody Visitors (ICV) scheme and had lead responsibility for reporting on custody issues.

3.2 The territorial policing commander was the chief officer lead on custody for the MPS. The custody directorate had an inspection function for audit and compliance, health and safety and the implementation of SDHP guidance. The commander sat on the programme board for SDHP and was clearly focused on ensuring an emphasis on 'professionalising custody'. 'Virtual courts' were being piloted through video links in some custody suites, including the borough operational command unit (BOCU) of Croydon.

3.3 Policies were signed off at a strategic command level within the MPS and the custody directorate provided standard operating procedures (SOPs) that supported delivery of force policies by custody suites in each BOCU. The SOPs covered a broad spectrum of matters, including use of police custody, use of closed-circuit television (CCTV) and guidance to custody staff on the supervision of detainees. They were designed to assist BOCUs to deliver consistent levels of service. The MPS had addressed previous reports on the use of untrained police constable (PC) gaolers by introducing an interactive computer based training package. They had also been given IT training in national strategy for police information systems (NSPIS), which allowed them to update custody records properly.

3.4 The BOCU commander reported that Croydon faced challenges with its cell capacity and its detainee throughput but major improvements were expected with the building of a new 40-cell complex in West Croydon due to be completed in May 2012.

3.5 There was positive and strong personal leadership from the BOCU commander and the senior management team (SMT) with a clear commitment to custodial provision. SMT members who carried out on-call duties were expected to visit both custody suites and inspect then against a checklist of standards. There was a clear and well defined command structure from the BOCU commander down to the custody manager. However, the custody manager had no responsibility for or line management of custody staff, who would still be line managed by operational inspectors under the proposed new structure.

3.6 The BOCU had a clear strategic meetings structure, which involved all the necessary partners. The BOCU commander chaired the Safer Croydon Partnership (SCP) and the Borough Criminal Justice Board (BCJB), which fed issues directly into the SCP. Custody staff fed into a BOCU daily management meeting and monthly performance meeting.

3.7 Staff in the custody suites were not posted there permanently, although there were plans to move to a permanent staffing regime in April 2011. Apart from PC gaolers, all staff had

received national approved custody training before they were deployed in the custody suite. The BOCU was supposed to have had 34 designated detention officers (DDOs), but it had only 19. As a consequence, Croydon used PC gaolers when there was a shortage of DDOs. The PC gaolers had had the NSPIS and gaoler training from the custody directorate. Staff currently worked 12-hour shifts with no built-in handover period, although the new regime would introduce shorter shifts and include handover time.

3.8 ICVs visited regularly and were focused on detainee welfare. Feedback reports were prepared after each visit and the MPA put together summary reports for quarterly ICV panel meetings. Concerns identified by ICVs were addressed either immediately by the custody sergeant or longer-term by the custody manager, with progress reports supplied to ICVs. The ICV chair reported good relationships with custody staff.

3.9 The police had a clear and active engagement with young people in the borough through the Youth Think Tank, and had invited young people on to the independent advisory group, a consultative group drawn from police and the local community.

3.10 Approximately 4% of custody records were randomly dip sampled for quality assurance, mainly by operational inspectors, but the process was ad hoc.

3.11 Newsletters from the custody directorate provided information and advice on detainee management and identified health and safety learning points gleaned from investigating successful interventions and near-misses. This included lessons learned from Independent Police Complaints Commission (IPCC) publications. The newsletters were sent to all staff and subsequently stored on a shared computer drive. However, few staff knew how to access them.

3.12 Use of force in custody suites was not collated at a local or force-wide level. Officers and staff recorded the use of force against detainees in their custody records and police officers recorded it in their evidential pocket notebooks. This meant that there was no management information accessible from a local or force-wide perspective.

Recommendations

3.13 The quantity and quality of custody records dip sampled should be improved.

3.14 The Metropolitan Police Service should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

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 Most custody staff treated detainees with consideration and respect. Some staff demonstrated a reasonable understanding of the specific needs of children and women in relation to use of force and family concerns, although the picture was mixed with other staff taking a 'one size fits all' approach. We were told that all female detainees were asked if they would like to speak with a female officer.

4.2 Staff told us they took detainees' cultural and religious needs into account, for example by allowing detainees to keep jewellery with religious significance. The Qur'an, Bible and Sikh holy book were available, although prayer mats were not. In some cells the direction of Mecca was indicated.

4.3 A hearing loop was available at Croydon, but otherwise there was little specific provision for detainees with disabilities. The booking-in desks had double handset telephones to enable some privacy when telephone interpreting services were used.

4.4 The booking-in areas at Croydon and South Norwood were cramped. There was little privacy when two detainees were processed side by side. At busy times the booking-in areas were crowded with police officers, solicitors and others. This contributed to a stressful atmosphere.

Recommendation

4.5 There should be a clearer focus on ensuring that the needs of all detainees are considered, including children, women and those with disabilities.

Housekeeping point

4.6 Staff working in custody should be aware of the availability of prayer mats and offer the use of them to detainees.

Safety

4.7 Our observations, and analysis of custody records, indicated that risk assessments of detainees on arrival lacked detail and that custody sergeants did not always ask supplementary questions (see main recommendation 2.20). One detainee in custody during the inspection who said he had once tried to kill himself was placed on constant watch, but little further information was sought about the suicide attempt and its circumstances. We also observed a custody sergeant running through the risk assessment too quickly, with little time for the detainee to make considered responses. The crowded conditions in the custody suites also made effective risk assessment difficult. Some custody sergeants said they sometimes

completed assessments in an interview room if privacy was required, but this seemed impracticable at busy times.

4.8 Procedures for checks and rousing detainees under the influence of drugs or drink were effective. New guidance on rousing had been issued, custody staff had received training, and there was a prominent sign on the cell door of each detainee who required rousing.

4.9 Shift patterns allowed no time for effective staff handovers, but staff arrived early for their shift to enable this to happen. Handovers took place between custody sergeants, but did not routinely include DDOs or PC gaolers on shift

Recommendation

4.10 Shift handovers should include all staff working in custody and cover issues relevant to the detainees held.

Good practice

4.11 *There were prominent cell door signs to remind custody staff of the correct rousing procedures.*

Use of force

4.12 Almost all detainees who arrived at the custody suite in handcuffs were released from them promptly. We were told at the two suites that all arrested persons (except those arriving at the police station by appointment) were handcuffed irrespective of the circumstances.

4.13 All custody staff received personal safety training twice a year. Custody staff told us that force would be used in the custody area as last resort, but there was insufficient recording and monitoring to determine how often force has been used and to collate, analyse and learn from such incidents (see strategy). There were good arrangements for detainees subject to the use of force to be seen by health care staff.

Recommendation

4.14 Detainees should only be handcuffed when a risk assessment indicates it is necessary for the safety of staff, the public or the detainee.

Physical conditions

4.15 The vast majority of cells were very safe. We found no ligature points in the Croydon custody suite, but there were a few ligature points relating to the old toilets at South Norwood, which could be easily rectified, and we pointed these out to the BOCU.

4.16 The custody suites were run down, including torn and defaced posters in the booking-in areas, although good standards of cleanliness were maintained. There were problems with heating and ventilation at South Norwood. Some cells were very cold; we found one detainee sitting on the floor with his back to the heating grilles because, he said, that was the only way he could

keep warm. Yet other cells were excessively hot. An air conditioner was kept running in the corridor but this was very noisy. A no-smoking policy was strictly enforced.

4.17 The interview rooms at South Norwood were in a poor condition. There was much graffiti, and the rooms were hot and stuffy. At Croydon, demands for interview rooms caused considerable delays in interviewing and too many people waiting in the booking-in area. We observed one legal interview that was interrupted because the interview room was required for a virtual court session.

4.18 Cell call bells were explained to detainees and, with the authority of a custody sergeant, could be isolated for only 10 minutes at a time. They were tested regularly. Annual practice fire evacuations had been held and were recorded.

Recommendations

4.19 The heating and ventilation of cells and the condition of the interview rooms at South Norwood need remedial attention.

Personal comfort and hygiene

4.20 Pillows and mattresses were available to detainees and in reasonable condition and wiped down between uses. Blankets were worn but clean. All cells had toilets but none had washbasins, so detainees had to ask to use the basins in the corridor. Toilet paper was only available on request. In our survey, only 4% of respondents said that they had been offered a shower. There was evidence that the shower at South Norwood had been used recently, although the water was cold. We found that one detainee had been held for almost 39 hours without being offered a shower.

4.21 There were good stocks of toothpaste, razors etc, and female detainees were offered sanitary products on arrival. The view of the toilet area was obscured on the CCTV images of the cells.

4.22 There were stocks of replacement clothing, including paper suits, tracksuits and plimsolls. We talked with detainees whose clothes had been taken for evidence and who were in paper suits, although tracksuits were available. Staff told us that supplies of tracksuits were limited and often unavailable for long periods. They encouraged family and friends to bring in replacement clothes when needed.

Recommendations

4.23 All detainees who are held overnight or who need a shower should be offered one.

4.24 Unless there is a forensic reason to do so, replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed.

Housekeeping point

4.25 Toilet paper should be provided in each cell (subject to risk assessment).

Catering

4.26 Meals for detainees in South Norwood were provided from the 24-hour police station canteen. The staff canteen in Croydon was closed for refurbishment and microwave meals were provided in unsatisfactory but temporary conditions. There was a good stock of a reasonable range of meals, including halal and vegetarian. Staff told us that water and hot drinks were provided on request. Detention officers had been trained to heat food to an appropriate temperature. There were no probes to test the temperature of microwaved meals.

Housekeeping point

4.27 A temperature probe should be used to ensure microwaved meals are served at the correct temperature.

Activities

4.28 Neither suite had an exercise area, and no exercise was offered. At South Norwood, we were told that occasionally a detainee could be taken into the police station yard in handcuffs, but the yard was overlooked by homes and offices. Visits were allowed in principle at the discretion of the custody officer but did not happen in practice. Juveniles could only have visits when a family member acted as an appropriate adult. There was a small stock of books at each suite but, despite the relatively large number of immigration detainees held, these were only in English, and there were few magazines. In our custody record analysis, only one detainee out of 30 had been offered a magazine.

Housekeeping points

4.29 The stock of reading materials should be improved to cater for the specific needs of detainees who are young, non-English speakers or have limited literacy.

4.30 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods of time.

5. Individual rights

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

Rights relating to detention

5.1 We observed custody sergeants checking the circumstances of the individual's offence and arrest to determine if detention was appropriate. Most custody sergeants could recall only a few occasions when they had refused to detain. Although alternatives to custody, such as voluntary attendance, were readily available, we were told that officers preferred to arrest and process the suspect through the custody suite.

5.2 Staff assured us that custody suites were never used as a place of safety for children under Section 46 of the Children Act 1989.

5.3 Detainees were given a pamphlet summarising their rights and entitlements. Custody sergeants downloaded and printed information for non-English speaking detainees about their rights in their own languages. A professional telephone interpreting service was readily available and we were informed that there was a good face-to-face interpreter service.

5.4 Custody staff liaised well with UK Border Agency (UKBA) officers to expedite the processing of immigration detainees. We observed a custody sergeant telling UKBA staff that he could only accept detainees on their way to the custody suite if UKBA arranged interpreters before their arrival. This was done and booking-in proceeded smoothly. Between June and December 2010, the average time spent by immigration detainees at the Croydon custody suites was just under 16 hours.

5.5 Detainees were routinely asked if they wanted someone informed of their detention and whether they had dependants. We observed detainees making telephone calls and being asked if they wanted to consult a solicitor. Those who declined a solicitor were told they could change that decision later.

5.6 Reviews of detainees while they were in custody were mostly undertaken by a police inspector who had specific PACE responsibilities, and our observations and analysis of custody records confirmed that these generally took place on time.

5.7 There was a pre-release risk assessment list of questions in the NSPIS custody system which was used for all detainees before their release, although we saw examples of detainees with clear vulnerabilities who were released without consideration of these issues (see main recommendation 2.21).

Recommendation

5.8 Police officers should be encouraged to make use of alternative to custody processes where appropriate, such as voluntary attendance at the police station.

Rights relating to PACE

5.9 Solicitors told us they were satisfied that detainees' rights were properly upheld. They did not report any problems in obtaining copies of custody records and said there was a good professional relationship with custody staff, although they sometimes spent much time waiting about. However, in our survey only half of respondents said that they had had a solicitor present during the interview, against the comparator of nearly three-quarters. We observed custody sergeants offering detainees the PACE Codes of Practice and this booklet was readily available, although rarely requested.

5.10 We saw no examples of detainees who were interviewed when intoxicated or under the influence of drugs.

5.11 Family members or friends were usually contacted if an appropriate adult was required. If this was not possible or appropriate, there were appropriate adults for juvenile detainees who could be obtained easily during office hours through the local youth offending service. Staff said there were difficulties in obtaining appropriate adults after 6.30pm in South Norwood and after 10.30pm in Croydon. There were sometimes difficulties in finding appropriate adults for vulnerable adults through social services, which relied on only two or three volunteers. The force adhered to the PACE definition of a child (as a person under 17) instead of the Children Act definition, which meant those aged 17 were not given an appropriate adult unless they were otherwise deemed to be vulnerable.

5.12 We were told that the local authority could rarely accommodate juveniles who were charged before their attendance at court (in 'PACE beds'), which led to juveniles being kept in police custody overnight.

5.13 Court cut-off times were very good, and custody officers were usually able to get detainees who were not suitable for the virtual court into the magistrates' court until approximately 3pm on weekdays and at least 10am on Saturday. However, we were told that the virtual court was often problematic. It was considered as inefficient by all the solicitors we spoke to and also took DDOs away from their primary role of ensuring detainee safety and welfare. A custody sergeant also told us about three detainees who had waited all day for the virtual court but could not be dealt with, and were further remanded overnight thus avoidably prolonging their detention by 24 hours.

5.14 The handling and processing of DNA samples was very good, with clear procedures for continuity of evidence and collection of samples. We identified only a couple of problems with the storage of multiple forensic samples from different cases in single bags, which had the potential to create cross-contamination or a loss of samples.

Recommendations

5.15 Senior police officers should engage with the local authorities in London to ensure the provision of local authority accomodation for juveniles who have had bail denied.

5.16 Appropriate adults should be readily available for both juveniles, including those aged 17 years, and vulnerable adults.

5.17 The Metropolitan Police Service should review the suitability of operating virtual courts at both Croydon suites.

Rights relating to treatment

5.18 Detainees were not routinely told they could make a complaint. Copies of the relevant IPCC leaflet were available but not displayed. Complaints were usually taken from detainees once they had been released. There was also no procedure to take complaints from detainees who were not released from police custody, that is, those taken to court or remanded by the virtual court.

Recommendation

5.19 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance[5] and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody.

[5] IPCC statutory guidance (2010)

6. Health care

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

Clinical governance

6.1 Nurses employed by the MPS forensic health service (FHS) had been introduced to the custody suites in 2010 and were present 24 hours a day at Croydon; they visited South Norwood once a day or more frequently on request. The custody staff and forensic medical examiners (FMEs) we talked to welcomed the nursing service. FMEs provided telephone advice, consultation and prescribing after they were called by the nurse. Detainees had a choice of the gender of the health care professional, and interpreting services were available via telephone or face-to-face.

6.2 Clinical governance of the nursing staff was good with regular appraisal, supervision and training in team building and forensic health care. Clinical governance arrangements for FMEs were not robust and it was unclear how the FHS assured itself that FMEs had appropriate credentials, appraisal, supervision and training. FMEs told us that training opportunities previously provided by the MPS had now ceased, as had monthly peer support meetings. FMEs were responsible for maintaining their own professional registration and ongoing professional training. The FMEs believed that there was no formal system to verify locum doctors' qualifications.

6.3 Not all FMEs were approved clinicians under Section 12 of the Mental Health Act and their backgrounds were from general practice and other medical specialties. Communications between custody staff and health care professionals were good, and health care was represented at the custody users' meeting involving the police and local stakeholders. The borough senior nurse manager was based at Croydon.

6.4 The health care professional rooms at Croydon and South Norwood were both accessed from the main custody areas. The room at South Norwood was much smaller than the one at Croydon. The examination couches were robust but the heights could not be varied, which could be a hazard for health care professionals. There was good attention to the privacy and confidentiality of detainees during consultations with the doors closed, although there were no privacy screens.

6.5 There was no evidence that an infection control audit had been carried out at either site, although guidance on the control of communicable diseases was available on the FHS intranet. Cleaning schedules were not displayed, although the health care professional rooms were cleaned twice daily and cleanliness was monitored by the nurses. The floor covering in both suites was old and required re-sealing, and some furniture required replacement, but both rooms had areas that were clinically clean. The layout of the room at Croydon meant that the detainee sat between the health care professional and the door during consultation, which could compromise the safety of the health care professional.

6.6 The management of medicines was undertaken by the nurses and was very good with stock control and daily checks of both generic and controlled drugs. There were no refrigerators to store heat-sensitive products.

6.7 Emergency equipment, including an automatic external defibrillator, was located behind the custody desk. It was in date and was checked by the nurses. There was no epipen (adrenaline) or airways with the equipment. We were informed that there had been a problem in obtaining adrenaline but that it was now in stock and available to order; and that it was not FHS policy to deploy airways. Health care professionals and custody staff knew how to use the equipment and received regular emergency life support training.

Recommendations

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

6.9 The health care professional consultation rooms should be refurbished and redecorated, and refrigerators should be installed.

6.10 The forensic health service should review its policy on the range of equipment and drugs available to health care professionals for use in emergencies, specifically airways and adrenaline.

Housekeeping points

6.11 There should be clear infection control procedures, and compliance with these should be subject to audit.

6.12 The examination couch in the consultation rooms should have variable height adjustment.

6.13 Privacy screens should be provided in the consultation rooms.

6.14 The layout of the consultation room at Croydon should ensure health care professional safety.

Patient care

6.15 New arrivals were asked if they wanted to see a health care professional, or custody officers referred them to one if they presented any health-related concerns. Nurse and FME response times were entered on the custody record. Custody staff and nurses said that delays in FME response times of between two and seven hours were not uncommon, and we found similar examples in our analysis of custody records. The borough health service manager was available to respond to complaints about health care. In our survey, only 27% of detainees said that the quality of health care was good, yet complaints were rare; they were usually about waiting times for FMEs.

6.16 Detainees were asked if they were on prescribed medication and, if necessary, police officers collected personal medication from their home. They were seen by a nurse and treatment was continued if appropriate, or initiated by a nurse using patient group directions. Records of administration were documented in the FHS paper clinical records and on NSPIS. Symptomatic relief of withdrawal from substances was available. Prescribing and administration of methadone by the FME followed guidelines, including the avoidance of prescribing within the first six hours of arrival in custody to avoid overdose risk. However, as this depended on the attendance of the FME, it was often delayed.

6.17 Health care professionals and custody staff had access to NSPIS, which contained data fields for health care entries. The health care professionals left sufficient clinical information on NSPIS to help custody staff assist with the health care of detainees. Some said they gave legal representatives a copy of the detainee's clinical notes on request. Nurses originated FHS paper clinical records that were used and stored in accordance with the Caldicott principles on the confidentiality of personal health information and Data Protection Act. FMEs made their own clinical notes that they took away with them for private storage.

Recommendation

6.18 FMEs should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance on the confidentiality of personal health information.

Substance use

6.19 In our survey, 60% of detainees said that they had a drug or alcohol problem. There was a comprehensive Croydon criminal justice intervention programme protocol signed in 2009 by the police, probation, mental health and drug service providers. Drug services were provided by the Westminster Drug Project, a registered charity. A drug intervention programme (DIP) worker was based at Croydon during weekdays between 7am and 10pm, and visited South Norwood daily or more frequently if required. DIP criminal justice workers covered the borough custody suites and magistrates' court, so they could follow the progress of substance users through the judicial process. Out of hours the custody staff allotted detainees who required support to pre-arranged appointment times with DIP workers.

6.20 In our survey, 57% of respondents said that they had been offered access to a drug/alcohol worker on arrival in custody, and in our custody record analysis 23% (seven out of 30) were intoxicated when they came into detention. We observed DIP workers going to cells several times a day offering support to known substance users and other detainees. Detainees taken into custody overnight were checked in the morning, and anyone who tested positive to drugs was assessed and followed up in custody and on release. DIP workers liaised with custody sergeants and were alerted whenever an offence triggered a drug test. Where necessary, a care plan was completed and detainees were signposted to community services, including the local needle exchange service.

6.21 Detainees with alcohol problems were directed to local charities specialising in alcohol dependence, although we were told that some services for people with alcohol problems and juveniles had recently ceased. Some detainees seen by the DIP workers had a dual diagnosis, and they were supported to make contact with the psychiatric services. We were told that there was regular liaison between DIP workers and mental health services. DIP workers also supported homeless detainees to identify their housing needs, and signposted juveniles to age-appropriate services.

Mental health

6.22 In our custody record analysis, 27% (eight out of 30) indicated that the detainee had mental health problems. Mental health services were provided by the South London and Maudsley NHS Foundation Trust (SLaM).

6.23 No mental health workers were based in the custody suites but there was a 24-hour trust helpline that health care professionals used to identify detainees known to mental health services and their prescribed medications. A court diversion scheme at Croydon magistrates' court operated on one day a week. It was not known how many people were diverted from custody in this way.

6.24 Detainees with mental health concerns were initially seen by the nurses who, when necessary, requested the support of an FME and/or referred to an approved mental health professional for a Mental Health Act assessment – their response times were said to be very good. Detainees with mental health problems were put in cells with CCTV to minimise the risk of harm and, if required, DDOs provided a constant watch. We were told that custody staff received occasional mental health awareness training.

6.25 There was a draft joint operational policy for the reception and care of service users admitted under Section 136 of the Mental Health Act 1983 signed by relevant agencies, including SLaM and Croydon police. Police custody was used infrequently for Section 136 (once a month in the previous 14 months). The Section 136 suite at SLaM that served the Croydon borough had been closed since February 2010 for refurbishment but was due for completion after our visit. People subject to Section 136 were taken to Brixton, Camberwell or Lewisham for assessment.

6.26 We observed one person on Section 136 detained in police custody during our visit. She had been detained at 5.30am and there was no Section 136 suite place available. The Mayday Hospital casualty department had declined to take her, despite NHS leaflets advising individuals in crisis to attend their local accident and emergency departments (see recommendation 6.27). The woman was detained in Croydon police custody, referred to the approved mental health professional service, and transported to an NHS facility at 4.45pm, over 11 hours into the emergency. During her stay in police custody, she had experienced several acute psychotic episodes. The nurse on duty, custody staff, escorting police officers and ambulance staff demonstrated exceptional skill in effecting her transfer.

Recommendation

6.27 Croydon police should work with the South London and Maudsley NHS Foundation Trust (SLAM) to clarify their respective roles in assisting people with acute mental health problems.

7. Summary of recommendations

Main recommendations

To the Metropolitan Police Service

7.1 Staff should ensure that detainees have the opportunity during the booking-in process to outline any concerns or areas of vulnerability. (2.20)

7.2 Pre-release risk assessment of detainees should consider all known risk factors, and staff should take appropriate action to ameliorate them when needed. (2.21)

Recommendations

To the Metropolitan Police Service

Strategy

7.3 The quantity and quality of custody records dip sampled should be improved. (3.13)

7.4 The Metropolitan Police Service should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (3.14)

Treatment and conditions

7.5 There should be a clearer focus on ensuring that the needs of all detainees are considered, including children, women and those with disabilities. (4.5)

7.6 Shift handovers should include all staff working in custody and cover issues relevant to the detainees held. (4.10)

7.7 Detainees should only be handcuffed when a risk assessment indicates it is necessary for the safety of staff, the public or the detainee. (4.14)

7.8 The heating and ventilation of cells and the condition of the interview rooms at South Norwood need remedial attention. (4.19)

7.9 All detainees who are held overnight or who need a shower should be offered one. (4.23)

7.10 Unless there is a forensic reason to do so, replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed. (4.24)

Individual rights

7.11 Police officers should be encouraged to make use of alternative to custody processes where appropriate, such as voluntary attendance at the police station. (5.8)

7.12 Senior police officers should engage with the local authorities in London to ensure the provision of local authority accomodation for juveniles who have had bail denied (5.15).

7.13 Appropriate adults should be readily available for both juveniles, including those aged 17 years, and vulnerable adults. (5.16)

7.14 The Metropolitan Police Service should review the suitability of operating virtual courts at both Croydon suites. (5.17)

7.15 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance[6] and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.19)

Health care

7.16 Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners (FMEs), including locums. (6.8)

7.17 The health care professional consultation rooms should be refurbished and redecorated, and refrigerators should be installed. (6.9)

7.18 The forensic health service should review its policy on the range of equipment and drugs available to health care professionals for use in emergencies, specifically airways and adrenaline. (6.10)

7.19 FMEs should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance on the confidentiality of personal health information. (6.18)

7.20 Croydon police should work with the South London and Maudsley NHS Foundation Trust (SLAM) to clarify their respective roles in assisting people with acute mental health problems. (6.27)

Housekeeping points

Treatment and conditions

7.21 Staff working in custody should be aware of the availability of prayer mats and offer the use of them to detainees. (4.6)

7.22 Toilet paper should be provided in each cell (subject to risk assessment). (4.25)

7.23 A temperature probe should be used to ensure microwaved meals are served at the correct temperature. (4.27)

7.24 The stock of reading materials should be improved to cater for the specific needs of detainees who are young, non-English speakers or have limited literacy. (4.29)

7.25 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods of time. (4.30)

[6] IPCC statutory guidance (2010)

Health care

7.26 There should be clear infection control procedures, and compliance with these should be subject to audit. (6.11)

7.27 The examination couch in the consultation rooms should have variable height adjustment. (6.12)

7.28 Privacy screens should be provided in the consultation rooms. (6.13)

7.29 The layout of the consultation room at Croydon should ensure health care professional safety. (6.14)

Good practice

7.30 There were prominent cell door signs to remind custody staff of the correct rousing procedures. (4.11)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Kellie Reeve	HMIP inspector
Paddy Craig	HMIC inspector
Paul Tarbuck	HMIP health care inspector
Huw Jenkins	CQC inspector
Roger James	CQC inspector
Laura Nettleingham	HMIP senior researcher
Amy Summerfield	HMIP research trainee

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population at HMP High Down, who had been through a police station in the borough of Croydon, 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 22 February 2011. A list of potential respondents to have passed through Croydon or South Norwood police stations was created, listing all those who had arrived from Croydon magistrates' court within the past two months.

Selecting the sample

In total, 64 respondents were approached; 10 reported being held in police stations outside Croydon. On the day, the questionnaire was offered to 54 respondents: there were four refusals, five questionnaires returned blank and two answered the questions in relation to police custody outside Croydon. All of those sampled had been in custody within the last three months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. No respondents were interviewed.

Methodology

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

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

- 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.

Response rates

In total, 43 (80%) 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 about which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses are excluded from the analysis.

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 38 police areas since April 2008.

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

Summary

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

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

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

Police custody survey

Section 1: About you

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	9 (21%)
17-21 years	5 (12%)	*50-59 years*	1 (2%)
22-29 years	16 (37%)	*60 years or older*	1 (2%)
30-39 years	11 (26%)		

Q4 Are you:

Male	40 (98%)
Female	0 (0%)
Transgender/transsexual	1 (2%)

Q5 What is your ethnic origin?

White - British	22 (51%)
White - Irish	0 (0%)
White - other	2 (5%)
Black or black British - Caribbean	7 (16%)
Black or black British - African	5 (12%)
Black or black British - other	1 (2%)
Asian or Asian British - Indian	2 (5%)
Asian or Asian British - Pakistani	1 (2%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	3 (7%)
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	5 (13%)
No	33 (87%)

Q7 What, if any, would you classify as your religious group?

None	14 (33%)
Church of England	9 (21%)
Catholic	8 (19%)
Protestant	1 (2%)
Other Christian denomination	2 (5%)
Buddhist	0 (0%)
Hindu	1 (2%)
Jewish	0 (0%)

Muslim 8 (19%)
Sikh 0 (0%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 39 (93%)
Gay/lesbian/homosexual 1 (2%)
Bisexual 2 (5%)

Q9 Do you consider yourself to have a disability?
Yes 7 (17%)
No 35 (83%)

Q10 Have you ever been held in police custody before?
Yes 39 (91%)
No 4 (9%)

Section 2: Your experience of this custody suite

Q11 How long were you held at the police station?
Less than 24 hours 12 (28%)
More than 24 hours, but less than 48 hours (2 days) 13 (30%)
More than 48 hours (2 days), but less than 72 hours (3 days) 15 (35%)
72 hours (3 days) or more 3 (7%)

Q12 Were you given information about your arrest and your entitlements when you arrived there?
Yes 34 (79%)
No 6 (14%)
Don't know/can't remember 3 (7%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 25 (58%)
No 13 (30%)
I don't know what this is/I don't remember 5 (12%)

Q14 If your clothes were taken away, were you offered different clothing to wear?
My clothes were not taken 23 (53%)
I was offered a tracksuit to wear 11 (26%)
I was offered an evidence/paper suit to wear 3 (7%)
I was offered a blanket 0 (0%)
Nothing 6 (14%)

Q15 Could you use a toilet when you needed to?
Yes 37 (88%)
No 4 (10%)
Don't know 1 (2%)

Q16 If you have used the toilet there, was toilet paper provided?
Yes 10 (25%)
No 30 (75%)

Q17 Did you share a cell at the police station?

Yes	2 (5%)
No	40 (95%)

Q18 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	18 (42%)	11 (26%)	14 (33%)
Ventilation/air quality	14 (33%)	9 (21%)	19 (45%)
Temperature	9 (21%)	7 (16%)	27 (63%)
Lighting	23 (55%)	9 (21%)	10 (24%)

Q19 Was there any graffiti in your cell when you arrived?

Yes	26 (62%)
No	16 (38%)

Q20 Did staff explain to you the correct use of the cell bell?

Yes	10 (23%)
No	33 (77%)

Q21 Were you held overnight?

Yes	39 (91%)
No	4 (9%)

Q22 If you were held overnight, which items of clean bedding were you given?

Not held overnight	4 (8%)
Pillow	10 (19%)
Blanket	23 (44%)
Nothing	15 (29%)

Q23 Were you offered a shower at the police station?

Yes	2 (5%)
No	41 (95%)

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

Yes	1 (2%)
No	42 (98%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	36 (84%)	7 (16%)
Drink?	36 (88%)	5 (12%)

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

Very good	*Good*	*Neither*	*Bad*	*Very Bad*	*N/A*
0 (0%)	2 (5%)	5 (12%)	14 (33%)	20 (47%)	2 (5%)

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

I did not have any food or drink	2 (6%)
Yes	19 (53%)
No	15 (42%)

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

I do not smoke	6 (14%)
I was allowed to smoke	2 (5%)
I was not offered anything to cope with not smoking	34 (81%)
I was offered nicotine gum	0 (0%)
I was offered nicotine patches	0 (0%)
I was offered nicotine lozenges	0 (0%)

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

Yes	1 (2%)
No	42 (98%)

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

Yes	19 (44%)
No	16 (37%)
I don't know	0 (0%)
I didn't want to inform anyone	8 (19%)

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

Yes	22 (51%)
No	21 (49%)

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

My telephone call was not denied	28 (72%)
Yes	3 (8%)
No	8 (21%)

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

	Yes	*No*
Who was taking care of your children	5 (14%)	30 (86%)
Contacting your partner, relative or friend	16 (41%)	23 (59%)
Contacting your employer	7 (19%)	29 (81%)
Where you were going once released	11 (30%)	26 (70%)

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

Yes	39 (91%)	
No	4 (9%)	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	19 (50%)	13 (34%)	6 (16%)
Appropriate Adult	1 (4%)	13 (54%)	10 (42%)
Interpreter	0 (0%)	14 (56%)	11 (44%)

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

I did not requested a solicitor	14 (35%)
2 hours or less	7 (18%)
Over 2 hours but less than 4 hours	5 (13%)
4 hours or more	14 (35%)

Section 3: Safety

Q38 Did you feel safe there?

Yes	27 (64%)
No	15 (36%)

Q39 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes	15 (36%)
No	27 (64%)

Q40 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	27 (50%)	*Because of your crime*	10 (24%)
Insulting remarks (about you, your family or friends)	7 (17%)	*Because of your sexuality*	1 (2%)
Physical abuse (being hit, kicked or assaulted)	5 (12%)	*Because you have a disability*	1 (2%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	1 (2%)
Your race or ethnic origin	1 (2%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	1 (2%)		

Q41 Were your handcuffs removed on arrival at the police station?

Yes	29 (71%)
No	10 (24%)
I wasn't handcuffed	2 (5%)

Q42 Were you restrained while in the police custody suite?

Yes	10 (24%)
No	31 (76%)

Q43 Were you injured while in police custody, in a way that you feel was not your fault?

Yes	8 (19%)
No	34 (81%)

Q44 Were you told how to make a complaint about your treatment if you needed to?

Yes	5 (12%)
No	36 (88%)

Section 4: Health care

Q46 Did you need to take any prescribed medication when you were in police custody?

Yes	15 (36%)
No	27 (64%)

Q47 Were you able to continue taking your prescribed medication while there?

Not taking medication	27 (64%)
Yes	7 (17%)
No	8 (19%)

Q48 Did someone explain your entitlements to see a health care professional if you needed to?

Yes	16 (40%)
No	20 (50%)
Don't know	4 (10%)

Q49 **Were you seen by the following health care professionals during your time there?**

	Yes	*No*
Doctor	12 (34%)	23 (66%)
Nurse	19 (53%)	17 (47%)
Paramedic	1 (4%)	26 (96%)
Psychiatrist	1 (4%)	26 (96%)

Q50 **Were you able to see a health care professional of your own gender?**

Yes 7 (18%)
No 22 (55%)
Don't know 11 (28%)

Q51 **Did you have any drug or alcohol problems?**

Yes 25 (61%)
No 16 (39%)

Q52 **Did you see, or were offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems 16 (40%)
Yes 14 (35%)
No 10 (25%)

Q53 **Were you offered relief or medication for your immediate symptoms?**

I didn't have any drug/alcohol problems 16 (40%)
Yes 3 (8%)
No 21 (53%)

Q54 **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*
13 (31%)	1 (2%)	7 (17%)	8 (19%)	7 (17%)	6 (14%)

Q55 **Did you have any specific *physical* health care needs?**

No 26 (63%)
Yes 15 (37%)

Q56 **Did you have any specific *mental* health care needs?**

No 33 (83%)
Yes 7 (18%)

Prisoner survey responses for Croydon police custody 2011

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

		Croydon police custody 2011	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		**43**	**1348**
SECTION 1: General information			
3	Are you under 21 years of age?	**12%**	**9%**
4	Are you transgender/transsexual?	**2%**	**1%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**44%**	**31%**
6	Are you a foreign national?	**14%**	**15%**
7	Are you Muslim?	**18%**	**11%**
8	Are you homosexual/gay or bisexual?	**6%**	**2%**
9	Do you consider yourself to have a disability?	**16%**	**20%**
10	Have you been in police custody before?	**90%**	**91%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24 hours?	**72%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**80%**	**74%**
13	Were you told about PACE?	**58%**	**52%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**57%**	**43%**
15	Could you use a toilet when you needed to?	**88%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**26%**	**50%**
17	Did you share a cell at the station?	**4%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**42%**	**31%**
18b	Ventilation/air quality?	**33%**	**22%**
18c	Temperature?	**20%**	**15%**
18d	Lighting?	**55%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**61%**	**54%**
20	Did staff explain the correct use of the cell bell?	**24%**	**22%**
21	Were you held overnight?	**90%**	**92%**
22	If you were held overnight, were you given **no** clean items of bedding?	**35%**	**28%**
23	Were you offered a shower?	**4%**	**10%**
24	Were you offered a period of outside exercise?	**2%**	**7%**
25a	Were you offered anything to eat?	**84%**	**80%**
25b	Were you offered anything to drink?	**88%**	**84%**
	For those who had food:		
26a	Was the quality of the food and drink you received 'good'/'very good'?	**4%**	**12%**
26b	Was the food/drink you received suitable for your dietary requirements?	**56%**	**44%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**95%**	**93%**
28	Were you offered anything to read?	**2%**	**14%**
29	Was someone informed of your arrest?	**44%**	**43%**
30	Were you offered a free telephone call?	**52%**	**50%**

Key to tables

		Croydon police custody 2011	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		
31	If you were denied a free call, was a reason given?	**25%**	**14%**
32	Did you have any concerns about:		
32a	Who was taking care of your children?	**15%**	**15%**
32b	Contacting your partner, relative or friend?	**41%**	**53%**
32c	Contacting your employer?	**19%**	**20%**
32d	Where you were going once released?	**30%**	**31%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**50%**	**72%**
34b	Appropriate adult	**4%**	**7%**
34c	Interpreter	**0%**	**7%**
35	Did you wait over four hours for your solicitor?	**53%**	**65%**
SECTION 3: Safety			
39	Did you feel unsafe?	**35%**	**39%**
40	Has another detainee or a member of staff victimised you?	**35%**	**41%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**16%**	**20%**
41b	Physical abuse (being hit, kicked or assaulted)	**12%**	**14%**
41c	Sexual abuse	**0%**	**2%**
41d	Your race or ethnic origin	**2%**	**5%**
41e	Drugs	**2%**	**15%**
41f	Because of your crime	**25%**	**17%**
41g	Because of your sexuality	**2%**	**1%**
41h	Because you have a disability	**2%**	**3%**
41i	Because of your religion/religious beliefs	**2%**	**3%**
41j	Because you are from a different part of the country than others	**0%**	**4%**
42a	Were your handcuffs removed on arrival at the police station?	**74%**	**73%**
42b	Were you restrained while in the police custody suite?	**25%**	**16%**
43	Were you injured while in police custody, in a way that you feel is not your fault?	**19%**	**24%**
44	Were you told how to make a complaint about your treatment?	**13%**	**13%**
SECTION 4: Health care			
46	Did you need to take any prescribed medication when you were in police custody?	**35%**	**51%**
47	For those who were on medication: were you able to continue taking your medication?	**47%**	**35%**
48	Did someone explain your entitlement to see a health care professional if you needed to?	**40%**	**35%**
49	Were you seen by the following health care professionals during your time in police custody?		
49a	Doctor	**34%**	**47%**
49b	Nurse	**52%**	**18%**
	Percentage seen by either a doctor or a nurse	**60%**	**53%**
49c	Paramedic	**3%**	**4%**
49d	Psychiatrist	**3%**	**3%**
50	Were you able to see a health care professional of your own gender?	**17%**	**28%**
51	Did you have any drug or alcohol problems?	**60%**	**54%**
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	**57%**	**41%**
53	Were you offered relief medication for your immediate symptoms?	**11%**	**32%**
54	For those who had been seen by health care, would you rate the quality as good/very good?	**27%**	**29%**
55	Do you have any specific physical health care needs?	**36%**	**32%**
56	Do you have any specific mental health care needs?	**17%**	**24%**