Report on an inspection visit to police custody suites in

Metropolitan Police Service Borough Operational Command Unit of Havering

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

30 July – 1 August 2013

Glossary of terms

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Any enquiries regarding this publication should be sent to HMI Prisons at the address below, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

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Her Majesty's Inspectorate of Prisons
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Victory House
6th floor
30-34 Kingsway
London WC2B 6EX
England

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Section 1. Introduction

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

The inspection looked at the custody suites serving the London Borough of Havering 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. Day-to-day management of custody was delegated to the borough operational command unit (BOCU) commander.

The borough commander provided strategic leadership for the custody function, with custody discussed at a range of meetings. Staffing arrangements were reasonable and detainees were well cared for. As we have found elsewhere, there was a lack of appropriate monitoring of the use of force, both locally and London-wide.

Staff handovers were conducted well, although there needed to be several in each 24-hour period because of the shift patterns. Risk assessments were reasonable but pre-release risk assessments were often perfunctory. The suite was clean, with minimal graffiti, and cell checks were recorded daily. Interactions with detainees were good, particularly with young people.

There was a culture of keeping detainees in custody overnight, rather than pursuing their cases, partly due to a lack of available staff at certain times to progress cases. The Police and Criminal Evidence Act (PACE) was adhered to. Juveniles and vulnerable adults were well served by an appropriate adult scheme. Arrangements for taking complaints were not understood by custody staff.

Nurses had recently been withdrawn from the suite, which had caused concern for the custody staff because of delays in getting forensic medical examiners (FMEs) to arrive at the suite. There was no mental health liaison scheme, which inevitably led to delays in getting detainees assessed. Custody was rarely used as a place of safety under the Mental Health Act 1983.

Overall, custody provision in Havering was good, with evidence of consideration and care being given to detainees. However, some detainees stayed in custody for too long and the new staffing model had resulted in any sense of a 'team spirit' being lost. The lack of nurses and the reliance on an overstretched FME service was of concern, and mental health services needed developing.

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

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons January 2014

Section 2. Background and key findings

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

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

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

2.4 This unannounced inspection was conducted at the police custody suite in the MPS borough operational command unit (BOCU) of Havering. We examined force-wide and BOCU custody strategies. There was just one custody suite of 14 cells in Romford. In the financial year 2012/13, 5,271 detainees had been held in the suite.

2.5 A survey of prisoners at HMP Pentonville who had formerly been detained at the Havering suite was conducted by HM Inspectorate of Prisons researchers (see Appendix II).

Strategy

2.6 The delivery of custody services had been devolved to the borough operational command unit (BOCU), and the BOCU commander held responsibility for this.

2.7 Safe and decent delivery of custody was assured through strategic leadership from the borough commander, with a detective superintendent being the senior leadership team lead for custody. The borough had moved to the new MPS local policing model for staffing; this had resulted in some detrimental changes to staffing levels and shift patterns in custody. Staff told us that they rarely worked with the same colleagues on different shifts and that the 'team ethos' had been lost. Nevertheless, we found that the care provided to detainees was good. The borough used the MPS template for dip-sampling custody records, and this included the checking of person escort record (PER) forms and closed-circuit television

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

(CCTV) recordings. There were processes for dealing with successful interventions, and these were discussed at various meetings.

2.8 There was interaction with partner organisations at a strategic level but little engagement at a tactical level and no regular meetings with partner organisations at a practitioner level. The independent custody visitors (ICVs) reported a good relationship with the police and said that issues raised were addressed promptly. All custody staff had received training before working in custody but there was no process to ensure that police constable (PC) gaolers had received custody-specific training before working in the custody suite.

Treatment and conditions

2.9 Staff engaged well with detainees, and the diverse needs of detainees were generally met, although provision for those with disabilities was poor. Religious items were available but staff had no easy way of identifying the direction of Mecca for Muslim detainees.

2.10 Risks were managed appropriately, but our analysis of custody records found some examples of juveniles being observed too infrequently. We saw some good staff handovers, although, because of the new staffing model, they had to take place many times in a day and it was difficult to see how everyone was briefed satisfactorily. Pre-release risk assessments were perfunctory.

2.11 All cells were clean, with minimal graffiti, although some had poor natural light. Detainees were provided with mattresses, pillows and blankets, and were able to take a shower. The toilet area in cells was obscured on the CCTV monitors but detainees were not routinely provided with toilet paper. There was a limited stock of replacement clothing. Food was supplied from the staff canteen, when it was open, and ambient microwave meals were available at other times. No reading materials were offered and there was no outside exercise area.

Individual rights

2.12 Custody sergeants routinely checked the grounds for detention, and 'caution +3' (voluntary attendance) was used. Immigration detainees were usually moved on quickly. There were delays in dealing with detainees who arrived late in the day, due to a lack of staff to progress their case. This resulted in detainees being held in custody for long periods.

2.13 All under-18-year-olds were treated as juveniles, in line with the latest ACPO guidance. Relatives or friends were usually called on to act as appropriate adults (AAs) for juveniles and vulnerable adult detainees. When this was not possible, there were options available to provide these, although because the custody suite often held detainees from different London boroughs and the arrangements for AAs differed across boroughs, there was the potential for delays in getting them to attend.

2.14 Detainees were able to make use of an 'initial contact language kiosk' to aid the booking-in process, which catered for 20 foreign languages and sign language for those with a hearing impairment. Staff reported difficulties in using the system as its use became negated if a detainee provided an answer outside the scripted prompt list, necessitating the use of a telephone interpreting service.

2.15 Due to a rationalisation of the local courts, there were sometimes problems in getting detainees to court, which prolonged their time in custody. Detainees arrested for breach of bail sometimes had to be released because of time constraints.

2.16 Staff told us that if a detainee wished to make a complaint they would advise the duty officer. However, we witnessed a detainee being told that he should go to the front counter of the police station to complain about his treatment which meant that detainees who went to court were not given an opportunity to complain.

Health care

2.17 The recent removal of MPS-employed nurses from the suite, as part of an MPS-wide strategy to allocate nurses to the busiest suites, had led to staff concerns about delays in getting forensic medical examiners (FMEs) to attend the suite. Medications were stored appropriately. Nicotine replacement therapy was not available. Opiate substitution therapy was not offered but symptomatic relief was available. Detainees were able to see a substance misuse worker and were referred on after custody, as appropriate.

2.18 There was no mental health liaison and diversion scheme, and there were delays in getting mental health assessments done. The custody suite was rarely used as a place of safety for persons detained under section 136 of the Mental Health Act 1983.[2]

Main recommendation

2.19 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and establish learning for the force.

[2] 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.

Section 3. Strategy

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

Strategic management

3.1 The MPS had a territorial policing criminal justice (TPCJ) directorate, led by a commander in territorial policing headquarters. A superintendent was responsible for the day-to-day management of the TPCJ directorate.

3.2 Responsibility for the day-to-day management of the custody suite and delivery of custody services had been devolved to the BOCU. There was no custody lead member of staff from the London Mayor's Office for Policing and Crime for the Metropolitan Police, so it was unclear how they were able to be aware of custody issues. The TPCJ directorate had an inspection function for audit and compliance, health and safety, and the implementation of the Authorised Professional Practice (APP) on Detention and Custody published by the College of Policing.

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

3.4 The borough commander exercised strategic leadership of the custody function. In the senior leadership team (SLT), a detective superintendent of operations led the custody function, and managed a chief inspector with responsibility for custody. The chief inspector managed a custody manager and a custody support inspector. There was evidence that SLT members regularly visited the custody suites.

3.5 The TPCJ directorate maintained an organisational risk register for all MPS custody suites. The BOCU commander led the local work on risks and had introduced measures to mitigate them. Members of the SLT carried out regular compliance checks in custody by reviewing two risks from the risk register on each visit to custody.

3.6 Staffing in the custody suite was adequate and comprised nine permanent custody sergeants, who were managed by the custody manager. We were told that backfill sergeants were used infrequently to cover for staff redeployment.

3.7 Custody sergeants were supported by permanent designated detention officers (DDOs), who were responsible for the care and welfare of detainees and were line managed by the custody sergeants. However, the custody sergeants and DDOs worked a different shift pattern, making line management difficult, with some DDOs reporting that they had not worked with their line manager for some time and that the 'team ethos' had been lost. DDOs had received training to book in detainees under the supervision of custody sergeants.

3.8 Although there were sufficient DDOs on duty during the inspection, we were told that the borough had too few DDOs, with PC gaolers used to cover gaps.

3.9 A member of the SLT chaired three daily 'pacesetter' meetings, attended by the custody chief inspector, who could raise custody issues as necessary. Custody was discussed by exception at the weekly SLT meeting, and there was a quarterly custody user group meeting for custody sergeants and a separate quarterly meeting for DDOs, chaired by the custody manager. The minutes of both these meeting showed that they were productive and well attended. The custody chief inspector had regular informal liaison with the custody manager/custody support inspector. Custody health and safety matters were discussed at the quarterly BOCU health and safety meeting, chaired by the BOCU commander.

3.10 Custody work was quality assured and the custody manager was expected to check a sample of custody records. We were told that the borough used the MPS template for dip-sampling custody records, which was comprehensive and included the checking of PER forms and CCTV recordings. The dip-sampling included a focus on staff handovers, which the custody manager/custody support inspector attended whenever possible.

3.11 There were processes for dealing with successful interventions, based on a form passed on to the custody manager, custody chief inspector and TPCJ directorate. Successful interventions were an agenda item at the quarterly health and safety meetings as well as at monthly themed SLT meetings – for example, on risk management. Learning from successful interventions was communicated to staff either face to face or via email. Independent Police Complaints Commission (IPCC) 'learning the lessons' information was put on the force intranet, and managers expected staff to visit the site regularly to update themselves. Staff we spoke to were aware of these documents but rarely accessed them.

Recommendation

3.12 The Metropolitan Police Service should work with the London Mayor's Office for Policing and Crime to ensure that it allocates one member as a lead for custody matters.

Partnerships

3.13 There was interaction with partner organisations at a strategic level, including the Borough Criminal Justice Board, attended by the borough detective chief inspector, but little engagement at a tactical level and no regular meetings at a practitioner level.

3.14 There was an established joint ICV scheme covering the boroughs of both Havering and Redbridge, with weekly visits to the suite at Romford. ICVs said that immediate issues were dealt with effectively and they received feedback on outstanding issues. Police staff regularly attended panel meetings.

Learning and development

3.15 All DDOs and custody sergeants on custody duties had received training before working in custody. However, there was no process to ensure that PC gaolers had received custody-specific training before working in custody. Yearly mandatory training was provided for custody sergeants, and staff we spoke to had either received this training or were scheduled to attend.

3.16 There was no borough custody newsletter produced, and although staff accessed the TPCJ directorate website, which highlighted MPS-wide issues and provided guidance on SOPs, they told us that it would not be the first place they looked for information. Custody-trained

sergeants had to apply for refresher training, and the borough had no oversight of training records for staff working in custody.

Recommendations

3.17 Police constable gaolers should receive custody-specific training before working in custody.

3.18 There should be regular engagement with partner organisations at a practitioner level through a custody user group

Housekeeping point

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

Section 4. Treatment and conditions

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

Respect

4.1 All staff engaged with detainees in a professional and respectful manner and custody staff demonstrated a good level of care towards detainees. The holding area for detainees waiting to be booked in was very small and had no seating. We saw one detainee waiting in this area for over 30 minutes, in handcuffs. He became agitated and had to be verbally calmed down by a DDO, who handled the situation well.

4.2 There was a lack of clarity about the role of DDOs; even when there were sufficient staff on duty, we saw police officers taking detainees to and from cells, carrying out searches, taking fingerprints and, inappropriately, taking an oral swab from a detainee at the booking-in desk in full view of others. The booking-in area lacked privacy. The height of the booking-in desk was suitable to facilitate good communication but there were no privacy screens between booking-in terminals, and detainees were often booked in within the sight and hearing of other detainees, police officers and solicitors. There was no discreet booking-in area which could be used for sensitive matters.

4.3 Girls under the age of 16 were not allocated a named female officer responsible for their care. Women coming into custody were asked if they wanted to speak to a female officer and if they might be pregnant.

4.4 There was limited specific provision for young people. There were two designated detention rooms for children and young people but these were normal cells, assigned to such detainees simply because they were located close to the booking-in desk. Interactions with young people were good. We saw custody sergeants patiently explaining the booking-in process to young people who had been arrested, ensuring that the language used was age appropriate and that the detainees understood it.

4.5 There was step-free access into the custody suite and we were told that detainees using wheelchairs had been accommodated several times in the previous 12 months. However, provision for detainees with disabilities was poor. There were no adapted cells with lowered cell call bells, and there was no adapted shower room or toilet. All the bed plinths were low, and there were no thick mattresses to raise their height, which meant that older detainees or those with disabilities would struggle to rise from them. There were no hearing loops or Braille materials available but there was a video on the initial contact kiosk, enabling detainees to read through the booking-in process (see section on individual rights).

4.6 Prayer mats and holy books were available and stored respectfully. We saw a Bible being provided to a detainee on request. There was no reliable way of determining the direction of Mecca for Muslim detainees.

4.7 Custody sergeants and DDOs were aware of the needs of transgender detainees when they were searched.

4.8 Custody sergeants asked all detainees if they had dependants. We saw a 16-year-old detainee being asked if he had any caring responsibilities for a parent or sibling. Sergeants and DDOs had a good awareness of safeguarding issues affecting young people and vulnerable adults, and of the details of agencies for referral if they identified any concerns.

Recommendations

4.9 Detention officers should ensure that detainees are looked after and kept safe.

4.10 Booking-in desks should allow private communication between custody staff and detainees.

4.11 Provision for detainees with disabilities should be improved.

Housekeeping points

4.12 Seating should be provided in the holding area.

4.13 Girls aged 16 or under should be allocated a female officer responsible for their care.

4.14 A supply of thick mattresses should be available to raise the height of the bed plinths for detainees who require it.

4.15 There should be a means for indicating the direction of Mecca.

Safety

4.16 Custody sergeants conducted the initial risk assessment and asked a set of questions concerning health, risk and individual needs contained in the national strategy for police information systems (NSPIS) custody record system. The initial questions were not always delivered in a manner that would encourage a detainee to divulge their concerns, but we saw custody sergeants appropriately asking supplementary questions when any vulnerabilities were disclosed. Our analysis of 30 custody records showed that initial risk assessments generally included a sufficient level of detail and there was evidence of information from the Police National Computer (PNC) being added where appropriate. For example, one detainee did not disclose a history of self-harm during booking-in but this was discovered after checking the PNC, and influenced the subsequent care plan.

4.17 Custody sergeants were proportionate in managing risk and did not routinely remove detainees' clothes with cords attached. They used the risk assessment to determine the level of management required. Detainees were generally placed on the appropriate level of observation, although there were exceptions to this. For example, in our custody record analysis we found two instances where detainees under the age of 16 had been placed on 60-minute visits, and a third case where a detainee in custody for the first time had also been placed on 60-minute visits. However, we also found an example of an elderly detainee being placed on 30-minute visits on account of his age.

4.18 Staff had a good understanding of rousing procedures for detainees who were intoxicated, and our custody record analysis found a good level of detail about detainee responses to rousing checks.

4.19 All custody staff carried single-use anti-ligature knives. There was no rip-resistant safety clothing. There was CCTV coverage in eight of the 14 cells as well as in all corridors and at the booking-in desk. However, the screen definition of cell CCTV was poor.

4.20 The recently introduced shift pattern made it difficult for all incoming and outgoing custody staff to be involved in the sharing of information, as staff came on and went off duty at several times in the day, and it was difficult to see how everyone was briefed satisfactorily. However, we saw an excellent handover in the afternoon, for which the booking-in area had been cleared, and all staff took part.

4.21 A leaflet containing details of support organisations was generally given to those leaving custody for whom vulnerability issues had been identified. Custody sergeants had no access to travel warrants or money for transport costs. Staff said that they would contact someone at the detainee's home, if necessary, and that the police took the most vulnerable people home; we found an example of this in our custody record analysis, where the police had taken a pregnant woman home so that she would not have to use public transport.

4.22 Our custody record analysis showed that pre-release risk assessments (PRRAs) were completed for all detainees, including those being transferred back to prison or to court. However, Most PRRAs were perfunctory, stating that there were no issues on release, or that these had been addressed. There were a few instances where the risk assessment recorded how the detainee was getting home or that some additional information had been given to the detainee. One detainee had been offered a telephone call on leaving custody.

Recommendations

4.23 Closed-circuit television monitors should be upgraded so that staff can clearly observe detainees in the cells.

4.24 The quality of pre-release risk assessments should be improved.

Housekeeping points

4.25 Custody staff should not over-rely on national strategy for police information systems (NSPIS) prompts and should ask probing questions of detainees during both the initial and pre-release risk assessment, to ensure that risks are identified.

4.26 Borough custody managers should ensure that handover procedures are not compromised because of the current shift pattern.

Use of force

4.27 Very few detainees were brought into the custody suite handcuffed. When handcuffs were used, staff recorded the time that they were removed, with an indication that detainees had been checked for any resulting injuries. We spoke to several operational officers, who told us that they would only use handcuffs if they believed it to be justified. There was no use of force recording form. Staff recorded the use of force on the NSPIS system. Information on the use of force in custody suites was not collated locally or force-wide (see main

recommendation 2.19). All staff had been trained in approved safety techniques and received annual refresher training.

4.28 We saw a sergeant giving instructions for a strip-search to be undertaken, which was proportionate. The sergeant ensured that this was done in a cell not covered by CCTV. Data supplied by the force showed that strip-searching had been authorised 589 times between April 2012 and March 2013, which equated to approximately 11% of all arrests.

Physical conditions

4.29 All cells and the custody communal area were cleaned daily and were in a good, clean condition, with minimal graffiti. The cells were at an appropriate temperature but some cells had poor natural light.

4.30 DDOs made daily checks of the cells, which included checking cell call bells and the quality of mattresses and pillows, and looking for any potential ligature points. Check sheets were completed, and were reviewed daily by the custody inspector. Each cell was also checked by a DDO when a detainee was released.

4.31 We were told that there was a good response to calls for emergency repairs, and at the time of the inspection everything was in order. We saw a record of faults, which included the nature of the fault, the date and the time that it was reported. It was clear that these faults had been rectified within a reasonable timeframe.

4.32 DDOs explained the use of cell call bells and the toilet flush to all detainees when taking them to their cell for the first time, but this explanation was not always given if a police officer took the detainee to the cell. We saw a 14-year-old being taken to a cell by the arresting officer, who did not explain to the young person about the call bell, toilet flush or CCTV coverage. We saw custody staff responding promptly to cell call bells.

4.33 The custody suite had a fire evacuation policy and fire safety audits but there was no record of fire evacuation exercises, and the training record was incomplete. However, staff assured us that they had undertaken 'walk-through' exercises in the previous 12 months and we were satisfied that they were well versed in the fire evacuation process. Additional sets of handcuffs were available for an emergency evacuation. Smoking was not permitted in the custody suite.

Recommendation

4.34 Detainees should only be held in cells with adequate natural light.

Housekeeping points

4.35 DDOs should explain the use of cell call bells and the toilet flush to all detainees when taking them to their cell for the first time.

4.36 Fire evacuation/training records should be kept up to date.

Detainee care

4.37 Each cell had a mattress and pillow, which were wiped clean between uses. We found a good stock of clean blankets, although they were stored with used blankets, which posed an infection risk. There was a toilet in every cell and the toilet area was obscured on the CCTV monitor, although this was not always explained to detainees. We were told that toilet paper was available only on request, but we saw that a box of toilet paper had been provided in several cells, and staff confirmed that they provided it on a risk-assessed basis.

4.38 A variety of sanitary products was available for women but they were not routinely offered a hygiene pack. Toiletries such as toothpaste and soap were readily available. Showers were clean, worked well and were reasonably private. There were no cotton towels; detainees were expected to dry themselves using large sheets of paper towel. Staff told us that the showers were used daily, and we saw showers being facilitated during the inspection. However, our custody record analysis found that showers were not offered routinely to detainees. Three detainees (10%) who had been detained for between 23 and 51 hours had had a shower or wash while in custody. Five detainees (17%) who had later gone straight to court had not been offered a shower, four of whom had been in detention for over 22 hours.

4.39 There were limited stocks of replacement clothing, including tracksuit bottoms, T-shirts and plimsolls in several sizes. There was no underwear available but this was because the stock was waiting to be replenished.

4.40 Meals were given at recognised mealtimes and on reasonable request. Breakfast and lunch were usually provided from the police station canteen, and the evening meal was an ambient microwave meal. These catered for various dietary and religious needs. However, the food we saw served during the inspection looked very unappetising. The kitchen area was clean but the microwave oven was covered with dried food. Tea, coffee and water were freely available.

4.41 The exercise 'yard' comprised a room with a small open grille along the upper borders which provided some outside air. We spoke to two detainees who had been detained overnight; both indicated that they had requested outside exercise, but only one had managed to spend some time in this exercise area. In our survey, no respondents said that they had been offered exercise. Our custody record analysis showed that only two (17%) had received outside exercise, one of whom had been held for almost 40 hours and had requested exercise just four and a half hours into his detention. He had been told that he would be taken out when staff had the time; this had not happened until the following day, 16 hours after his initial request.

4.42 Reading material was limited to a few old newspapers and magazines. There was nothing in languages other than English, in easy-read formats or specifically for children and young people. We saw reading materials being offered only on request. In our custody record analysis, three detainees (10%) had been given reading materials. There were no closed visits facilities and we were told that family visits were seldom permitted.

Recommendations

4.43 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.

4.44 Detainees held for long periods should be offered outside exercise.

Housekeeping points

4.45 Staff should tell detainees that they cannot be seen using the toilet.

4.46 Hygiene packs should be routinely offered to female detainees.

4.47 Cotton towels should be provided to detainees.

4.48 Replacement underwear should be available.

4.49 The microwave oven should be kept clean.

4.50 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy.

Section 5. Individual rights

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

Rights relating to detention

5.1 We saw detainees being booked in promptly after arrival at the custody suite. Custody sergeants checked the reasons for detention with arresting officers to ensure that there were appropriate grounds. Sergeants told us that they were confident in refusing detention when the circumstances did not merit arrest and they were able to provide us with details of such cases.

5.2 Alternatives to custody, such as street bail and voluntary attendance (known locally as 'caution +3'), were available and staff believed that these had reduced the throughput in the custody suites. Figures supplied by the force showed that throughput had fallen from 6,498 detainees between April 2010 and March 2011 to 5,312 detainees between April 2012 and March 2013.

5.3 Custody sergeants were clear about their obligation to ensure that cases proceeded quickly. However, they indicated that delays were likely to occur if detainees arrived at the custody suite late in the evening, once the Community Safety Unit (CSU), which dealt with volume crime incidents, had completed their shift. In such cases, as only a limited number of CID officers were on night duty, detainees were likely to remain in custody until the morning, when they would be interviewed by the incoming CSU staff. In our analysis of 30 custody records, the average length of detention had been 15 hours and 10 minutes. This figure was similar to that provided by the force, which showed that between 1 April 2013 and 28 July 2013, the average detention time at the custody suite had been 13 hours and 35 minutes.

5.4 We were told that staff had a good relationship with UK Border Agency (now known as Home Office Immigration Enforcement) staff and most detainees who were to be transferred to immigration removal centres were collected from the custody suite within a short period. Figures supplied by the force showed that the custody suite dealt with low numbers of immigration detainees; for example, between 1 April 2013 and 28 July 2013, only 11 immigration detainees had been held.

5.5 There were three (10%) foreign nationals in the custody record sample we analysed. The detention logs indicated they had all been given their rights as a foreign national but none had chosen to have their Commission, Embassy or Consulate informed.

5.6 A professional telephone interpreting service was available to book in detainees who were unable to speak or read English and we saw it being used during the booking-in process. The custody suite had a double-handset telephone available at the booking-in desk and in the clinical room. Staff told us that, increasingly, the telephone interpreting service was unable to provide interpreters, depending on the language involved. During the inspection, the service was unable to provide a Hindi interpreter but, as an alternative, through agreement with the detainee, they were able to provide a Punjab-speaking interpreter. Staff told us that a good face-to-face interpreter service was available for interviews. The force had introduced 'virtual interpreters', who were available for interview purposes via video-conferencing. Detainees were given the choice of either using this alternative service or having an interpreter attend the custody suite.

5.7 The force had previously adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 had not been provided with an AA unless they were otherwise deemed vulnerable. However, following the judicial review of April 2013,[3] the force had adopted ACPO guidance and now contacted AAs on behalf of all young people under the age of 18. Family or friends were usually contacted in the first instance to act as an AA but when this was not possible, there were two schemes in operation; during office hours, the local youth offending team was available to assist young people, and outside these hours the service was provided by a private contractor. The private contractor also provided a 24-hour service for vulnerable adults. Staff told us that delays could be experienced between 8pm and 9am.

5.8 We were told that the local mental health team had occasionally attended and assisted as AAs, when detainees known to them had been in custody, but this had been arranged informally. Staff said that delays had been experienced when detainees from neighbouring boroughs had been brought to the custody suite as part of the MPS demand management model, resulting in long discussions between AA agencies while they agreed whose responsibility it was to attend.

5.9 Staff told us that they had never known PACE beds to be available for young people, but that they always contacted social services to check if one was available. In our custody record analysis, the detention logs did not record any attempt being made to secure alternative accommodation for two young people who had been held overnight and then transferred to court.

5.10 Staff assured us the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989.[4]

5.11 During booking-in, staff provided detainees with a detailed and informative leaflet summarising their rights and entitlements. A similar version could be downloaded from the custody intranet site and printed for non-English-speaking detainees in their own language. An easy-read pictorial format version of the rights and entitlements documentation was also available on the custody intranet; it was not available in Braille but a visual sign language version was available via the initial contact language kiosk, which was sited on a wall within the main booking-in area. This touch-button kiosk also catered for 20 main foreign languages, allowing a detainee to read and hear the booking-in process in their native language. However, staff reported difficulties in using the system as its use became negated if a detainee provided an answer outside the scripted prompt list, necessitating the use of a telephone interpreting service to gain the additional information necessary for managing risk. They therefore just used the telephone interpreting service, which they considered to be easier and quicker to use, for the entire booking-in process.

Recommendation

5.12 The Metropolitan Police Service should engage with the local authority to ensure the provision of safe beds for young people who have been charged but cannot be bailed.

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[3] In all other UK law and international treaty obligations, 17-year-olds are treated as children. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law.

[4] 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 there.

Housekeeping point

5.13 The force should begin to monitor and record details of all occasions when the telephone interpreting service is unable to provide an interpreter.

Rights relating to PACE

5.14 We saw detainees being told that they could read the PACE codes of practice during the booking-in process. Several new versions of PACE code C were available in the custody suite, but several out-of-date copies were also still present. Two posters were on display in the custody suite, advising detainees of their right to free legal advice in 12 languages rather than the usual 23 languages that we see in other forces. Solicitors we spoke to said that custody staff adhered to PACE. They reported no concerns, other than that they occasionally had to queue to access the two consultation rooms and three interview rooms because of the volume of demand. We witnessed some delays in access but the longest of these was only about 20 minutes. We saw solicitors routinely being offered a printout of their client's custody record without having to request this.

5.15 In our custody record sample, all detainees had been routinely offered legal advice during the booking-in procedure and 17 (57%) had accepted this offer. The detention logs indicated that solicitors had been contacted shortly after such requests. When detainees had initially declined legal advice, those remaining in custody long enough to receive a review had been reminded of their rights.

5.16 We observed detainees being told that they could inform someone of their arrest, and saw staff facilitating detainees in accessing telephone numbers on their mobile telephones. In our custody record sample, 27 detainees had been offered the opportunity of having someone informed of their arrest, but in the detention logs it was clear in only three cases that this course of action had been completed.

5.17 Reviews of detainees in custody were undertaken by the custody manager and the custody support inspector. In their absence, reviews were carried out by the duty officer. In our custody record sample, PACE reviews had not been necessary in 14 (47%) cases. Of the 16 (53%) detainees who had required a review, 14 had been carried out on time.

5.18 Five reviews had taken place while the detainees had been asleep and it was not clear from the detention logs if they had been reminded of their rights and entitlements on waking. Most of the reviews in our custody record analysis had been carried out face to face, which was the case for those we observed, although we saw one being conducted through the cell door hatch. Most of reviews we observed were thorough but the quality was still unclear.

5.19 All DNA samples were handled effectively, with regular collection from custody. Freezers were clearly labelled for their purpose.

5.20 Delays could be experienced in transporting detainees to Barkingside Magistrates' Court as detainees from the neighbouring boroughs of Barking and Dagenham and Ilford were also conveyed to this remand court. In addition, due to its limited cell capacity, the court was unable to accept the large number of detainees remanded over a weekend, so detainees were often remained in police custody until well into the afternoon, particularly on Mondays. Staff told us that it was not uncommon for detainees arrested for breach of court bail (and therefore having to appear in court within 24 hours) to be released from custody because of the delays involved in getting them accepted at the court custody suite. A prisoner escort contractor (PEC) was available for transportation for the morning court but was rarely able to provide transport for an afternoon court sitting. In the absence of the PEC, police officers

occasionally transported detainees to court. We were told that court cut-off times were variable and could be as early as noon or as late as 3pm on weekdays, with some flexibility on a day-to-day basis. All of these factors resulted in detainees being held in police custody for longer periods than necessary.

5.21 We were told that none of the PEC's vehicles, other than a small three-cell vehicle, could access the secure yard at Romford police station. We witnessed six detainees being walked out individually to board a cellular vehicle parked on the public pavement outside the police station, in view of passers-by. These detainees were left unattended on the vehicle until the last detainee had boarded as both PECs members of staff were required to escort the detainees. This raised concerns over the safety and security of the detainees left unaccompanied on the vehicle.

Recommendations

5.22 Senior police managers should engage with HM Courts and Tribunals Service and the local prisoner escort contractor to ensure that detainees are not held in police custody for longer periods than necessary.

5.23 Senior police managers should engage with the local prisoner escort contractor to ensure that detainees are transferred between both agencies in a safe and secure manner, which protects their privacy and dignity.

Housekeeping points

5.24 Posters advising detainees of their right to free legal advice should be in the usual 23 languages.

5.25 Subject to the limitations of PACE, a telephone call should be made when detainees ask for someone to be informed of their arrest, and a record to this effect should be made in the custody record.

5.26 Detainees should be informed of any reviews carried out while they were sleeping, and a record to that effect should be made in the custody record.

Rights relating to treatment

5.27 Custody staff said that if a detainee wished to make a complaint, they would immediately advise the duty inspector or custody manager, so that they could take the complaint. But we saw one detainee on release who indicated that he wished to make a complaint about his treatment during his time in police custody. He was told that he should report to the front counter, but staff were unsure how long he would have to wait to see the duty officer. The detainee asked if he could submit his complaint via email, rather than wait at the front counter, but staff did not know whether this was possible. We were told that the complaint had not been taken by custody staff as this would have delayed the detainee from being released, which was not an acceptable explanation.

Recommendation

5.28 Detainees should be able to make a complaint about their care and treatment, and be able to do so before they leave custody.

Section 6. Health care

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

Governance

6.1 The Metropolitan Police Forensic Health Service (FHS) provided health services, which custody staff said were responsive. Performance monitoring and clinical governance arrangements were good.

6.2 There was an FME on call at all times. The FHS checked FME credentials and offered appropriate training. There was clinical support from the lead FME as required. Interpreting services were available and used occasionally.

6.3 The clinical room was purpose designed but lacked natural light. There was no privacy screen. Infection control was generally good but there was heavy scaling of the taps. The room was not sufficiently clean; the floor had ingrained dirt, the examination bench, work surfaces and cupboard tops were dusty, and the examination couch paper cover roll had run out.

6.4 Airway support equipment and first-aid supplies were sited in several places; there was unnecessary duplication. Suction units were not assembled. There was an automated external defibrillator (AED), which custody staff were trained to use. Equipment was checked regularly, although some items were out of date or inefficient; these matters were dealt with when we brought them to the attention of custody staff. The AED check log had not been completed since mid-July 2013.

Recommendation

6.5 The emergency and first-aid kit, and its positioning, should be reviewed and all emergency equipment, such as suction units, should be ready for use.

Housekeeping points

6.6 A privacy screen should be provided in the clinical room.

6.7 There should be an annual audit of compliance with infection control standards and a plan to address issues of non-compliance.

6.8 The cleanliness of the clinical room should be monitored daily and action should be taken to address uncleanliness as it arises.

Patient care

6.9 Although 38% of detainees in our survey said that they had physical health care needs, not all detainees entering custody during the inspection were told that they could see a health care

practitioner if they wished. The target response time for an FME was two hours. Between April and June, 2013, inclusive, an FME had been called on 109 occasions (although for most of that period a nurse had usually been available on site); the average wait time was two hours and 52 minutes, the longest being 17 hours and 31 minutes. Following the withdrawal of on-site nurses in July 2013, as part of an MPS-wide strategy to allocate nurses to the busiest suites, custody staff had been concerned that response times would deteriorate. We saw an FME being called to see a detainee at 11.30am; he wished to prescribe over the telephone but this was refused for being against policy, and so he advised custody staff to telephone again at 12.30pm to request the next FME coming on duty to attend. Staff followed his instructions, but five hours later an FME had still not attended.

6.10 Clinical records were made electronically. Paper records such as illustrative body maps were stored securely. Health care instructions were recorded on detainees' custody records. We observed poor prescribing documentation in one case, making it difficult for custody officers to record medication administration.

6.11 Police officers attempted to retrieve detainees' medicines from their homes if necessary. Nicotine replacement and opiate substitution therapies were not offered, but symptomatic relief was available. Medicines stock management and control were good, although we found a British National Formulary from 2005. Medicines to be given to detainees were kept in individual trays or with property in locked rooms. Custody staff had not been familiarised with the medicines disposal system, previously operated by the nurses, which could have led to unnecessary risk.

Recommendations

6.12 All detainees should be offered the opportunity to see a health care practitioner when entering custody, and see them within the target response time.

6.13 Clinically indicated opiate substitutes and nicotine replacement therapy should be available to detainees, in line with national guidelines.

Housekeeping points

6.14 All medications should be prescribed on the correct forms.

6.15 Only up-to-date pharmacy reference materials should be retained.

6.16 Staff should be aware of the secure and auditable system for the disposal of discarded medications.

Substance misuse

6.17 In our custody record sample, nine (30%) detainees had entered custody under the influence of alcohol or substances. Substance misuse services were provided by Crime Reduction Initiative (CRI). Detainees and custody staff alike expressed satisfaction with the drug services. Detainees were offered the services of drug arrest referral workers, who were available from 6.30am to 10pm during the week. CRI offered an intensive programme, including test-on-arrest; required assessment as a condition of bail; conditional cautions; and treatment interventions for drugs and alcohol. Needle exchange was available from CRI offices. Juveniles were signposted to youth offending team services.

Mental health

6.18 In our survey, 38% of detainees (against a comparator of 25%) who had seen a health care practitioner said that they had specific mental health needs. Custody staff we spoke to had not received training in mental health awareness.

6.19 There was a monthly mental health liaison meeting between the police and North London Foundation Trust. There was no liaison and diversion scheme available, although the Trust had advanced plans to introduce one. When necessary, health care professionals referred detainees to the appropriate approved mental health professional (AMHP), who arranged for a Mental Health Act assessment. AMHPs were said to be responsive but the emergency duty team could take a long time to attend the custody suite, particularly in the evenings and at weekends. The Trust planned to reorganise services and introduce community mental teams from September 2013, which they hoped would prove more supportive to the police.

6.20 Police custody had been used only once as a place of safety under section 136 of the Mental Health Act 1983 in the previous three years. The Trust received about 400 police detainees for assessment per year, and the section 136 facility at Goodmayes Hospital was expanding to meet this need.

Recommendations

6.21 Custody staff should be trained in awareness of mental health problems to enable them to bring appropriate concerns to the attention of the health care practitioners.

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

Section 7. Summary of recommendations

Main recommendation

7.1 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and establish learning for the force (2.19).

Recommendations

Strategy

7.2 The Metropolitan Police Service should work with the London Mayor's Office for Policing and Crime to ensure that it allocates one member as a lead for custody matters. (3.12)

7.3 Police constable gaolers should receive custody-specific training before working in custody (3.17).

7.4 There should be regular engagement with partner organisations at a practitioner level through a custody user group (3.18).

Treatment and conditions

7.5 Detention officers should ensure that detainees are looked after and kept safe. (4.9)

7.6 Booking-in desks should allow private communication between custody staff and detainees. (4.10)

7.7 Provision for detainees with disabilities should be improved. (4.11)

7.8 Closed-circuit television monitors should be upgraded so that staff can clearly observe detainees in the cells. (4.23)

7.9 The quality of pre-release risk assessments should be improved. (4.24)

7.10 Detainees should only be held in cells with adequate natural light. (4.34)

7.11 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.43)

7.12 Detainees held for long periods should be offered outside exercise. (4.44)

Individual rights

7.13 The Metropolitan Police Service should engage with the local authority to ensure the provision of safe beds for young people who have been charged but cannot be bailed. (5.12)

7.14 Senior police managers should engage with HM Courts and Tribunals Service and the local Prisoner Escort Contractor to ensure that detainees are not held in police custody for longer periods than necessary. (5.22)

7.15 Senior police managers should engage with the local prisoner escort contractor to ensure that detainees are transferred between both agencies in a safe and secure manner, which protects their privacy and dignity. (5.23)

7.16 Detainees should be able to make a complaint about their care and treatment, and be able to do so before they leave custody. (5.28)

Health care

7.17 The emergency and first-aid kit, and its positioning, should be reviewed and all emergency equipment, such as suction units, should be ready for use. (6.5)

7.18 All detainees should be offered the opportunity to see a health care practitioner when entering custody, and see them within the target response time. (6.12)

7.19 Clinically indicated opiate substitutes and nicotine replacement therapy should be available to detainees, in line with national guidelines. (6.13)

7.20 Custody staff should be trained in awareness of mental health problems to enable them to bring appropriate concerns to the attention of the health care practitioners. (6.21)

7.21 There should be a mental health liaison and diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services. (6.22)

Housekeeping points

Strategy

7.22 There should be oversight of training records for staff working in custody to ensure that their training is up to date. (3.19)

Treatment and conditions

7.23 Seating should be provided in the holding area. (4.12)

7.24 Girls aged 16 or under should be allocated a female officer responsible for their care. (4.13)

7.25 A supply of thick mattresses should be available to raise the height of the bed plinths for detainees who require it. (4.14)

7.26 There should be a means for indicating the direction of Mecca. (4.15)

7.27 Custody staff should not over-rely on national strategy for police information systems (NSPIS) prompts and should ask probing questions of detainees during both the initial and pre-release risk assessment, to ensure that risks are identified. (4.25)

7.28 Borough custody managers should ensure that handover procedures are not compromised because of the current shift pattern. (4.26)

7.29 DDOs should explain the use of cell call bells and the toilet flush to all detainees when taking them to their cell for the first time. (4.35)

7.30 Fire evacuation/training records should be kept up to date. (4.36)

7.31 Staff should tell detainees that they cannot be seen using the toilet. (4.45)

7.32 Hygiene packs should be routinely offered to female detainees. (4.46)

7.33 Cotton towels should be provided to detainees. (4.47)

7.34 Replacement underwear should be available. (4.48)

7.35 The microwave oven should be kept clean. (4.49)

7.36 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy. (4.50)

Individual rights

7.37 The force should begin to monitor and record details of all occasions when the telephone interpreting service is unable to provide an interpreter. (5.13)

7.38 Posters advising detainees of their right to free legal advice should be in the usual 23 languages. (5.24)

7.39 Subject to the limitations of PACE, a telephone call should be made when detainees ask for someone to be informed of their arrest, and a record to this effect should be made in the custody record. (5.25)

7.40 Detainees should be informed of any reviews carried out while they were sleeping, and a record to that effect should be made in the custody record. (5.26)

Health care

7.41 A privacy screen should be provided in the clinical room. (6.6)

7.42 There should be an annual audit of compliance with infection control standards and a plan to address issues of non-compliance. (6.7)

7.43 The cleanliness of the clinical room should be monitored daily and action should be taken to address uncleanliness as it arises. (6.8)

7.44 All medications should be prescribed on the correct forms. (6.14)

7.45 Only up-to-date pharmacy reference materials should be retained. (6.15)

7.46 Staff should be aware of the secure and auditable system for the disposal of discarded medications. (6.16)

Section 8. Appendices

Appendix I: Inspection team

Elizabeth Tysoe	HMIP team leader
Fiona Shearlaw	HMIP inspector
Gary Boughen	HMIP inspector
Mark Ewan	HMIC staff officer
Paul Tarbuck	HMIP health services inspector
Tim Brackpool	Care Quality Commission inspector
Helen Ranns	HMIP researcher
Alissa Redmond	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

A voluntary, confidential and anonymous survey of the prisoner population at HMP Pentonville, who had been through a police station in the Metropolitan Borough of Havering, 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 July 2013. A list of potential respondents to have passed through Romford police station was created, listing all those who had arrived from Romford Magistrates' Court and Snaresbrook and Blackfriars Crown Courts within the past three months.[5]

Selecting the sample

In total 173 respondents were approached;[6] 157 respondents reported either being held in police stations outside of Havering and three could speak no English and so it was impossible to determine the police station they had been in. On the day, the questionnaire was offered to 16 respondents; there were three refusals. 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. In total 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, 13 (81%) respondents completed and returned their questionnaires.

Comparisons

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[5] 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.

[6] Survey was conducted concurrently with the survey for the Metropolitan Borough of Barking and Dagenham and respondents were asked whether they had been to a police custody suite in either Havering or Barking and Dagenham. In the event that a respondent had been to suites in both Havering and Barking and Dagenham they were asked to report on their experience at the suite they had been to most recently.

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 67 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 overnight' 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.

Survey results

Section 1: About you

Q2 Which police station were you last held at?

13 - Romford

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	1 (8%)
17-21 years	3 (23%)	*50-59 years*	0 (0%)
22-29 years	6 (46%)	*60 years or older*	0 (0%)
30-39 years	3 (23%)		

Q4 Are you:

Male	13 (100%)
Female	0 (0%)
Transgender/Transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	7 (54%)
White - Irish	0 (0%)
White - other	1 (8%)
Black or black British - Caribbean	2 (15%)
Black or black British - African	0 (0%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	1 (8%)
Mixed heritage - white and black Caribbean	1 (8%)
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	1 (8%)

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

Yes	3 (25%)
No	9 (75%)

Q7 What, if any, is your religion?

None	3 (23%)
Church of England	4 (31%)
Catholic	2 (15%)
Protestant	0 (0%)
Other Christian denomination	2 (15%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	2 (15%)
Sikh	0 (0%)

Q8 How would you describe your sexual orientation?

Straight/heterosexual	13 (100%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	0 (0%)

Q9 Do you consider yourself to have a disability?

Yes	3 (23%)
No	10 (77%)

Q10 Have you ever been held in police custody before?

Yes	12 (92%)
No	1 (8%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?

Less than 24 hours	3 (23%)
More than 24 hours, but less than 48 hours (2 days)	4 (31%)
More than 48 hours (2 days), but less than 72 hours (3 days)	4 (31%)
72 hours (3 days) or more	2 (15%)

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

Yes	9 (75%)
No	2 (17%)
Don't know/Can't remember	1 (8%)

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

Yes	7 (54%)
No	4 (31%)
I don't know what this is/I don't remember	2 (15%)

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

My clothes were not taken	6 (46%)
I was offered a tracksuit to wear	3 (23%)
I was offered an evidence/ paper suit to wear	3 (23%)
*I was **only** offered a blanket*	0 (0%)
Nothing	1 (8%)

Q15 Could you use a toilet when you needed to?

Yes	13 (100%)
No	0 (0%)
Don't Know	0 (0%)

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

Yes	6 (46%)
No	7 (54%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	5 (38%)	5 (38%)	3 (23%)
Ventilation/air Quality	2 (15%)	0 (0%)	11 (85%)
Temperature	2 (15%)	1 (8%)	10 (77%)
Lighting	6 (46%)	5 (38%)	2 (15%)

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

Yes	7 (54%)
No	6 (46%)

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

Yes	4 (31%)
No	9 (69%)

Q20 Were you held overnight?

Yes	11 (85%)
No	2 (15%)

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

Not held overnight	2 (15%)
Pillow	5 (38%)
Blanket	9 (69%)
Nothing	2 (15%)

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

Not held overnight / Did not get any bedding	4 (31%)
Yes	6 (46%)
No	3 (23%)

Q23 Were you offered a shower at the police station?

Yes	1 (8%)
No	11 (92%)

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

Yes	0 (0%)
No	13 (100%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	11 (85%)	2 (15%)
Drink?	11 (85%)	2 (15%)

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

Very good	*Good*	*Neither*	*Bad*	*Very Bad*	*N/A*
1 (8%)	0 (0%)	2 (17%)	4 (33%)	4 (33%)	1 (8%)

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

I did not have any food or drink	1 (8%)
Yes	7 (54%)
No	5 (38%)

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	1 (8%)
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	12 (92%)

Q29 Were you offered anything to read?

Yes	1 (8%)
No	12 (92%)

Q30 Was someone informed of your arrest?

Yes	4 (31%)
No	8 (62%)
I don't know	0 (0%)
I didn't want to inform anyone	1 (8%)

Q31 Were you offered a free telephone call?

Yes	3 (23%)
No	10 (77%)

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

My telephone call was not denied	5 (38%)
Yes	1 (8%)
No	7 (54%)

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

	Yes	*No*
Who was taking care of your children	0 (0%)	11 (100%)
Contacting your partner, relative or friend	5 (42%)	7 (58%)
Contacting your employer	1 (9%)	10 (91%)
Where you were going once released	3 (25%)	9 (75%)

Q34 Were you offered free legal advice?

Yes	11 (85%)
No	2 (15%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	2 (15%)
Yes	7 (54%)
No	4 (31%)

Q36 Were you interviewed by police about your case?

Yes	12 (92%)	
No	1 (8%)	If No, go to Q41

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor / Was not interviewed	2 (15%)
Yes	7 (54%)
No	4 (31%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult / Was not interviewed	5 (38%)
Yes	1 (8%)
No	7 (54%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter / Was not interviewed	7 (54%)
Yes	1 (8%)
No	5 (38%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	9 (69%)
No	4 (31%)

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

Yes	6 (46%)
No	7 (54%)

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

I have not been victimised	7 (54%)	*Because of your crime*	1 (8%)
Insulting remarks (about you, your family or friends)	2 (15%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	4 (31%)	*Because you have a disability*	0 (0%)
Sexual abuse	1 (8%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	1 (8%)	*Because you are from a different part of the country than others*	1 (8%)
Drugs	1 (8%)		

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

Yes	8 (62%)
No	4 (31%)
I wasn't handcuffed	1 (8%)

Q45 Were you restrained whilst in the police custody suite?

Yes	3 (23%)
No	10 (77%)

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

Yes	3 (25%)
No	9 (75%)

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

Yes	2 (15%)
No	11 (85%)

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

Very well	*Well*	*Neither*	*Badly*	*Very Badly*	*Don't remember*
1 (8%)	1 (8%)	4 (31%)	2 (15%)	4 (31%)	1 (8%)

Section 4: health care

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

Yes	4 (31%)
No	9 (69%)
Don't know	0 (0%)

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

	Yes	*No*
Doctor	6 (50%)	6 (50%)
Nurse	3 (33%)	6 (67%)
Paramedic	0 (0%)	8 (100%)

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

Yes	2 (17%)
No	9 (75%)
Don't know	1 (8%)

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

Yes	5 (38%)
No	8 (62%)

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

Not taking medication	8 (62%)
Yes	2 (15%)
No	3 (23%)

Q55 Did you have any drug or alcohol problems?

Yes	7 (54%)
No	6 (46%)

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	6 (46%)
Yes	4 (31%)
No	3 (23%)

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

I didn't have any drug/alcohol problems	6 (46%)
Yes	1 (8%)
No	6 (46%)

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*
5 (42%)	1 (8%)	1 (8%)	5 (42%)	0 (0%)	0 (0%)

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

Yes	5 (38%)
No	8 (62%)

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

Yes	5 (38%)
No	8 (62%)

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	8 (62%)
Yes	1 (8%)
No	4 (31%)

Prisoner survey responses for Havering Police 2013

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

		Havering Police 2013	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		13	2522
SECTION 1: General information			
3	Are you under 21 years of age?	**24%**	**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)	**38%**	**28%**
6	Are you a foreign national?	**26%**	**16%**
7	Are you Muslim?	**16%**	**10%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**24%**	**20%**
10	Have you been in police custody before?	**92%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**77%**	**68%**
12	Were you told your rights when you first arrived?	**75%**	**79%**
13	Were you told about PACE?	**54%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**44%**	**42%**
15	Could you use a toilet when you needed to?	**100%**	**91%**
16	If you used the toilet, was toilet paper provided?	**46%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**38%**	**34%**
17b	Ventilation/air quality?	**16%**	**23%**
17c	Temperature?	**16%**	**17%**
17d	Lighting?	**46%**	**44%**
18	Was there any graffiti in your cell when you arrived?	**54%**	**53%**
19	Did staff explain the correct use of the cell bell?	**30%**	**24%**
20	Were you held overnight?	**84%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**81%**	**87%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**66%**	**61%**
23	Were you offered a shower?	**9%**	**10%**

Key to tables

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	Percentages which are not highlighted show there is no significant difference		
24	Were you offered a period of outside exercise?	**0%**	**6%**
25a	Were you offered anything to eat?	**84%**	**81%**
25b	Were you offered anything to drink?	**84%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**9%**	**13%**
27	Was the food/drink you received suitable for your dietary requirements?	**59%**	**43%**
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**0%**	**6%**
29	Were you offered anything to read?	**8%**	**14%**
30	Was someone informed of your arrest?	**30%**	**45%**
31	Were you offered a free telephone call?	**24%**	**50%**
If you were denied a free telephone call:			
32	Was a reason given?	**13%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**0%**	**13%**
33b	Contacting your partner, relative or friend?	**41%**	**52%**
33c	Contacting your employer?	**9%**	**18%**
33d	Where you were going once released?	**26%**	**30%**
34	Were you offered free legal advice?	**84%**	**88%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**64%**	**72%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**64%**	**81%**
38	Was an appropriate adult present when you were interviewed?	**13%**	**29%**
39	Was an interpreter present when you were interviewed?	**17%**	**11%**
SECTION 3: Safety			
41	Did you feel unsafe?	**70%**	**62%**
42	Has another detainee or a member of staff victimised you?	**46%**	**34%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**16%**	**17%**
43b	Physical abuse (being hit, kicked or assaulted)	**30%**	**11%**
43c	Sexual abuse	**8%**	**2%**

Key to tables

		Havering Police 2013	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		
43d	Your race or ethnic origin	**8%**	**2%**
43e	Drugs	**8%**	**11%**
43f	Because of your crime	**8%**	**12%**
43g	Because of your sexuality	**0%**	**1%**
43h	Because you have a disability	**0%**	**2%**
43i	Because of your religion/religious beliefs	**0%**	**1%**
43j	Because you are from a different part of the country than others	**8%**	**3%**
44	Were your handcuffs removed on arrival at the police station?	**67%**	**73%**
45	Were you restrained while in the police custody suite?	**24%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**26%**	**23%**
47	Were you told how to make a complaint about your treatment?	**16%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**16%**	**36%**
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	**30%**	**34%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**50%**	**41%**
51b	Nurse	**34%**	**23%**
	Percentage seen by either a doctor or a nurse	**62%**	**50%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**17%**	**25%**
53	Did you need to take any prescribed medication when you were in police custody?	**38%**	**43%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**40%**	**32%**
55	Did you have any drug or alcohol problems?	**54%**	**52%**
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?	**56%**	**41%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**15%**	**25%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**30%**	**31%**
59	Did you have any specific physical health care needs?	**38%**	**31%**
60	Did you have any specific mental health care needs?	**38%**	**25%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**21%**	**13%**