Report on an inspection visit to police custody suites in the Metropolitan Police Service Borough Operational Command Unit of Hounslow

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by

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Contents

1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.[1] 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 Hounslow 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 had recently introduced processes to monitor custody provision within the BOCU and these procedures were still bedding in. There was a dedicated custody manager for the BOCU but most staff were not working in custody on a permanent basis, although this was being reviewed. Dissemination of Independent Police Complaints Commission 'learning the lessons' briefings needed improvement. No custody refresher training was taking place. As we have found elsewhere, there was a lack of appropriate monitoring of the use of force, both locally and London-wide.

The new prisoner escort service was causing delays and police facilities were being inappropriately used to hold remanded prisoners. Both suites were old, although in relatively good order. Cells were generally clean but some graffiti was evident. Interactions with detainees were generally appropriate but there was a mixed picture with regards to the attention paid to diversity issues, including ethnicity and faith, which was surprising considering the population within the borough. The booking-in arrangements did not provide sufficient privacy, and management data indicated a disproportionate use of strip-searching of detainees. Risk assessment and some elements of risk management were applied inconsistently.

An appropriate balance was maintained between progressing cases and the rights of individuals, and the Police and Criminal Evidence Act (PACE) was adhered to. Juveniles and vulnerable adults were well served by an appropriate adult scheme during the day but the lack of a night-time service and local authority PACE beds led to some juveniles being unnecessarily detained overnight. Arrangements for managing DNA and forensic samples were good but the arrangements for taking complaints were confused.

Health care provision was variable. We had considerable concerns regarding the management of medicines, and in particular stock control, which bordered on being dangerous. The training of staff for resuscitation, and the availability and checking of such equipment were effective. There were concerns about the response times of forensic medical examiners, and monitoring of this needed to be improved. Mental health liaison arrangements were excellent and provided opportunities for best practice to be adopted across the MPS. Custody was not used as a place of safety under the Mental Health Act.

[1] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

Overall, custody provision in Hounslow was mixed, with areas of good practice but clear issues which needed to be addressed. This report sets out a number of recommendations that we hope will assist the MPS and Metropolitan Police Authority to improve the facilities further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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November 2011

2. Background and key findings

2.1 The Metropolitan Police Service (MPS) operates 53 custody suites, 24 hours a day, to deal with the majority of detainees arrested during normal daily policing. A further 20 are reserved as 'overflow custody suites' and are used for various operational purposes. These include: charging centres for football matches, 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 74 custody suites designated under the Police and Criminal Evidence Act 1984 (PACE) for the reception of detainees.

2.2 This unannounced inspection was conducted at police custody suites in the MPS borough operational command unit (BOCU) of Hounslow. We examined force-wide and BOCU custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites. There were two custody suites, operating 24 hours a day: Hounslow, which had 12 cells, and Chiswick, with seven cells. We also visited Brentford, which had five cells and was used as an overflow custody facility. Between 1 January 2011 and 27 September 2011, custody suites in the BOCU had held 6,029 detainees. In the same period, 68 immigration detainees had been held.

2.3 A survey of prisoners at HMP Wormwood Scrubs who had formerly been detained in the suites was conducted by an HM Inspectorate of Prisons researcher and HM Inspectorate of Constabulary inspector (see Appendix II).[2]

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

Strategic overview

2.5 The MPS Criminal Justice Directorate (CJD), within the territorial policing team, had strategic oversight of custody in all boroughs in London. The Metropolitan Police Authority (MPA) had responsibility for the custody estate. The independent custody visitors (ICV) scheme was active and the borough was responsive to it.

2.6 Strategic oversight of custody within the borough was reasonable but some quality assurance mechanisms were new and not fully embedded. Some staff were permanent but most were temporary, brought in from the relief teams. Managers were not clear if all staff working in custody had been trained and no refresher training was offered. Dip-sampling of custody records had recently started. Partnership arrangements were well developed and there were particularly strong arrangements concerning mental health.

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

Treatment and conditions

2.7 Problems with the new prisoner escort contract service were resulting in delays and the use of police custody for people who should have been held in prison, some of whom were extremely vulnerable. Staff interactions with detainees were generally respectful and staff demonstrated a degree of flexibility. Awareness of diversity issues was mixed. Professional interpreting services were generally used when needed.

2.8 Risk assessments were carried out when detainees arrived in custody and the quality of these was variable. Some information relevant to risk was not accurately transferred between custody records and prisoner escort records (PERs). Some risk management appeared to be over-restrictive. Handovers between shifts took place but were inadequate. Non-custody police staff had access to detainees in cells. There was no monitoring of use of force. There was evidence that strip-searching was overused.

2.9 The custody suites were old and worn. Cells were generally clean but some graffiti was evident. We found no ligature points in cells. Closed-circuit television (CCTV) equipment was poor. Detainees were usually told how to use cell call bells and these were responded to promptly.

2.10 Detainees were provided with mattresses, pillows and blankets. Showers were rarely facilitated. The toilet area in cells was obscured on the CCTV monitors but detainees were not routinely provided with toilet paper. There was a good supply of replacement clothing, including underwear. Adequate food and drinks were provided. No reading materials were available and there was no outside exercise area.

Individual rights

2.11 There was a positive approach to balancing the priorities of progressing cases with the rights of individuals but little focus on the necessity test or alternatives to custody. Detainees were offered a copy of PACE codes of practice. The management of DNA and forensics was good.

2.12 Legal assistance was offered. Staff made calls to notify someone of the detainee's arrest. Children were not held in custody under section 46 of the Children Act 1989.[3] Immigration detainees were usually moved on quickly. Detainees were routinely asked if they had any dependency obligations. Pre-release risk assessments were completed but the quality varied.

2.13 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 reasonable options available to provide an AA for juveniles, although not out of hours or for vulnerable adults. Juveniles who could not be bailed were routinely held in police custody overnight.

2.14 Detainees were not routinely told how to make a complaint and the arrangements for taking complaints were poor.

[3] 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.

Health care

2.15 Primary health services were mixed. There were too many delays in the arrival of forensic medical examiners (FMEs) once called. Clinical governance arrangements for FMEs were unsatisfactory.

2.16 Medicines management arrangements were poor and potentially dangerous. Medical rooms were poorly equipped and dirty. Detainees could continue to take prescribed medication while in custody. Resuscitation equipment was available and custody staff were trained in its use. Substance misuse services were reasonable. Mental health services were well developed and detainees were not held under section 136 of the Mental Health Act 1983.[4]

Main recommendations

2.17 All staff required to work in custody should be adequately trained, including refresher training.

2.18 A comprehensive risk assessment should in all instances be completed, and the management of risk should be consistent with the risk management plan.

2.19 There should be safe pharmaceutical stock management; all medications should be stored safely and securely in line with national best practice and local policy.

[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 MPS had a CJD, led by a commander within territorial policing headquarters. A superintendent was responsible for the day-to-day management of the CJD. Responsibility for day-to-day management of Hounslow's custody suites and delivery of services had been devolved to the BOCU, and accountability therefore rested with the BOCU commander, who was a chief superintendent. There was a lead member from the MPA allocated to Hounslow, but no defined MPA lead for custody.

3.2 The CJD had an inspection function for audit and compliance, health and safety and the implementation of Safer Detention and Handling of Persons in Police Custody 2006 (SDHP) guidance.

3.3 Policies were signed off at a strategic command level within the MPS, and the CJD provided standard operating procedures (SOPs) which supported the delivery of force policies by custody suites in each London BOCU. The SOPs covered a broad spectrum of matters, including use of police custody, use of CCTV and guidance to custody staff on the supervision of detainees. They were designed to assist BOCUs to deliver consistent levels of service.

3.4 At BOCU operational level, the management team (SMT) consisted of a chief inspector lead for custody, who line-managed a dedicated custody manager, who was an inspector. There were two designated full-time custody suites in the borough – one at Hounslow and one at Chiswick. In addition, there was a suite at Brentford, which was not in use at the time of the inspection but had previously been used for Operation Safeguard detainees and during the public order disturbances in August 2011.

3.5 The BOCU regularly exceeded its cell capacity and had to utilise custody facilities outside the borough. The BOCU commander had been in discussion with the adjoining boroughs of Hillingdon and Ealing regarding the sharing of custody facilities.

3.6 The inspector undertaking the custody manager function for the borough was full time in this role. He had a deputy custody manager, who was a sergeant and also provided custody sergeant cover on an ad-hoc basis. A detention officer was also dedicated to providing support to the custody manager and assistant. The management of custody sergeants was devolved to the shift inspectors (duty officer).

3.7 The staffing levels in custody suites were adequate and comprised sergeants from the operational teams, supported by permanent civilian detention officers, who looked after the ongoing care and welfare of detainees. Resilience within the staffing of custody units was provided by sergeants from the operational teams for custody sergeants, and police constable (PC) gaolers for detention officers. At the time of the inspection, a decision had been made by the SMT to move to dedicated and centrally managed custody sergeants for the early and late shifts, with night shift cover continuing to be provided by the operational teams.

3.8 All custody sergeants and detention officers had received appropriate training before working in custody. However, PC gaolers received only minimal training for the role and we were told that some could not use the national strategy for police information systems (NSPIS). Yearly

mandatory training was provided to sergeants and DDOs but no custody refresher training. Detention officers were trained under Operation Herald to book in detainees, although this had not yet been formally implemented. A decision had been taken to allow detention officers to book in a limited number of detainees in straightforward cases under the supervision of the custody sergeant, to maintain their skills until the formal implementation of the scheme.

3.9 The BOCU managed risks associated with the custody function through the template provided by the Metropolitan Police Territorial Policing Criminal Justice (TPCJ) inspection team. Control measures had been identified and actions in relation to these updated.

3.10 Partnership arrangements were described as good but the BOCU commander was represented on the Local Criminal Justice Board by the Chief Inspector, Criminal Justice, which was unusual. The BOCU commander had regular meetings with the chief executive of the primary care trust and there were good links generally with health care providers. Relationships with the courts were described as good, although delays were experienced when dealing with the Crown Prosecution Service directly.

3.11 There was an established ICV scheme but due to resource issues in the recruitment and retention of ICVs, only 75% of visits had been completed in the previous year. Quarterly meetings were attended by the custody manager. ICVs told us that they were admitted to custody centres quickly and that staff were courteous and professional.

3.12 Custody issues, such as constant watches and successful interventions, were on the agenda at the daily management meeting and the quarterly borough health and safety meeting (which was attended by the custody manager), and could also be raised at the monthly SMT meeting and the weekly chief inspectors meeting with the BOCU commander, both by exception. Bail management was also discussed at the daily management meeting; this was a relatively recent initiative and the briefing process was not yet fully embedded into the meeting. The chief inspector held a weekly meeting with the custody manager and his team. There was no custody user meeting, and therefore no forum for practitioners to discuss issues.

3.13 Independent Police Complaints Commission (IPCC) 'learning the lessons' information and other custody-related circulations were emailed to staff by the custody manager, and he had set up a custody folder as a central repository for such information, but not all staff were aware of its existence.

3.14 The process for dealing with adverse incidents (successful interventions) and near misses appeared to be well established. A form was generated from the computer system in custody, with an audit trail of action from the custody manager to the BOCU commander and the CJD inspection team.

3.15 The custody manager dip-sampled one custody record per day from each of the custody suites. This process was recorded and provided an audit trail, which had identified quality issues, showing the remedial action taken. However, this process was not undertaken when the custody manager was absent.

Recommendation

3.16 Arrangements for the daily quality assurance of custody records through dip-sampling should be put in place when the custody manager is absent.

Housekeeping point

3.17 Independent Police Complaints Commission 'learning the lessons' briefings should be more easily accessible and staff should be reminded to use them.

Good practice

3.18 *The decision to allow detention officers to book in a limited number of detainees in straightforward cases under the supervision of the custody sergeant, until formal implementation of Operation Herald, was a sensible approach, allowing staff to maintain and develop the skills learned from the training course.*

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 Detainees were transported to the custody suites in both police and Serco Wincanton vehicles. Those we looked at were clean and in good condition. Serco Wincanton had recently taken over the contract for police detainee movements to and from custody in London and the South-East. At the time of the inspection, there were problems with this and, as a consequence, 'prison lock-out' prisoners were held overnight and over the weekend in police custody suites, including Hounslow. Some of these were particularly vulnerable and the conditions in police custody suites were unsuitable for them. There were also delays in detainee movements from custody to court (see paragraph 5.14 and recommendation 5.17).

4.2 The booking-in process was friendly and respectful and detainees were generally called by their first names. We saw detainees being booked in at both custody suites, and the process was generally carried out quickly after the detainee's arrival, although some faced short waits during busy times. Searches and the removal of detainees' property were conducted considerately, although at Hounslow spectacles and a Sikh detainee's Kara (bangle) were taken away, despite there being no indication that they might use them to harm themselves.

4.3 The booking-in desks were of a reasonable height to facilitate communication between custody staff and detainees. However, the layout of the booking-in areas offered little privacy, so sensitive information could be easily overheard if more than one detainee was being booked in. There was no area suitable for detainees with disabilities to be booked in.

4.4 Female detainees were always given the chance to speak to a female member of staff but no staff had received any specific training relating to the impact of detention on different groups. All staff were aware of the legal requirements relating to the treatment of juveniles. At Chiswick, juvenile detention cells were located some distance from the front desk but staff told us that if juveniles were vulnerable, they would locate them closer to the desk. At Hounslow, the detention rooms had no CCTV and staff told us they normally located juveniles in adult cells, where they could be observed more closely. There seemed little possibility that vulnerable juvenile detainees could be allowed to wait in an interview room rather than being placed in a cell. Staff had not had any refresher training in child protection awareness.

4.5 There were limited facilities for detainees with disabilities at either suite. Staff said that each detainee's needs were assessed individually and we saw that they allowed detainees to keep mobility aids if a risk assessment had shown it to be appropriate.

4.6 There were some materials available to allow detainees to observe their faith. A prayer mat, Qur'an and Bible were available on request at Chiswick. Although there was a prayer mat and compass available (to determine the direction of Mecca) at Hounslow, staff struggled to find a Qur'an. When it was found, it was in poor condition and not stored respectfully. There was a range of other holy books at this suite, including the Bible and the Torah. A Muslim detainee told us that he had not been offered the facility to pray, although he had not asked. Given the

ethnic diversity of the borough, we would have expected more attention to have been paid to these matters.

Recommendations

4.7 Staff should receive up to date awareness training on child protection and safeguarding.

4.8 There should be clear policies and procedures to meet the diverse needs of detainees, including those associated with faith, and those of women, juveniles and detainees with disabilities; custody staff should be trained to recognise these differing needs.

Safety

4.9 Detainees we spoke to felt safe in custody. All were subject to a risk assessment on arrival, and information relating to self-harm risks was obtained from the Police National Computer and transferred to the custody record.

4.10 The quality of initial risk assessments varied. Some were comprehensive and detailed but too many were not. In several instances, the detainee self-assessment section identified a number of vulnerabilities which were not reflected in the custody officers' section, although they were evident in the detention log entries. There were further anomalies in detention records; for example, in one instance a detainee who was quiet and compliant had later banged his head repeatedly on the cell floor and threatened to kill himself. He had then been restrained and put on constant watch, yet the custody record noted that there were no risks of self-harm, and the review that took place shortly after these incidents stated that there had been no change since the previous review. In our analysis of PERs, we found several instances in which the PER that had been given to the escort provider contained information about risk of self-harm which had not been noted in the custody record. Similarly, our custody record analysis raised some concerns about the recording of risk assessment. Initial risk assessment documents contained little information.

4.11 The monitoring of those at risk of self-harm involved different levels of observations according to the risks posed, with those at most risk considered for constant observation and those at less risk for hourly observations. Staff were familiar with the necessary requirements and gave good accounts of how they would manage detainees at risk of self-harm, and the levels of observation we observed were generally commensurate with the issues identified. Individual risks were actively managed and we observed good support offered to a vulnerable female detainee at Chiswick, although she was left to wander around the booking-in area while two male detainees were being booked in. In 25 (83%) of the records sampled, staff adhered to the agreed observation/monitoring levels for the detainee; however, among the five records for which this was not the case, we found a one hour 30 minute gap in entries for one detainee who had been placed under half-hourly observations.

4.12 Staff understood the importance of gaining a response from detainees subject to rousing checks, and the '4 Rs' mnemonic was prominently displayed on cell doors to remind them.

4.13 Detainees did not share cells. CCTV monitoring was used for detainees judged to be at high risk of self-harm and we did not observe this being used as a substitute for personal interactions. However, the CCTV system was outdated and of poor quality. The custody manager told us that he monitored four tapes per month but there was no audit trail for this.

4.14 Items such as belts, shoes and shoelaces were automatically removed from all detainees. Anti-ligature knives were available on bunches of cell keys but were not carried by all staff. DDOs had received training to identify potential ligature points, and were aware of the circumstances, risks and concerns of detainees in their care.

4.15 At both custody suites, we saw safety information being appropriately shared at custody sergeant handovers, although these did not involve DDOs, who had a separate handover.

Recommendations

4.16 Dip-sampling of custody records should include scrutiny of prisoner escort record forms, so that the discrepancies can be monitored and addressed.

4.17 Closed-circuit television (CCTV) systems should be updated to improve the quality and coverage of the images and to facilitate their retrieval. CCTV quality assurance should be recorded, with a clear audit trail.

4.18 All custody staff should carry anti-ligature knives.

4.19 Custody sergeants and detention officers should receive their handover together.

Use of force

4.20 New arrivals were given a rub-down search and checked with a metal detector. Handcuffs were removed as soon as possible. Staff were appropriately trained in use of force techniques, with refresher training taking place annually and an up-to-date record kept of those who had attended.

4.21 At Chiswick, we observed one female detainee being restrained and the situation was dealt with calmly and appropriately. We did not observe any use of force at Hounslow but custody sergeants there told us that detainees saw a health services professional if they were injured, in pain or on request after force was used.

4.22 Data provided by the MPS indicated that 15% of detainees at the Hounslow custody suites had been strip-searched since January 2011, compared with 1.5% at the Heathrow custody suite and 3–4% in similar London boroughs. Custody staff attributed this to the large proportion of detainees with drug problems in Hounslow (many of whom, they said, tended to hide drug paraphernalia on their person) and the large number of detainees arrested in connection with violent incidents. This issue needed further examination.

4.23 There was no central recording of the use of force in custody, with a record being made only in the custody record and officer's notebook. The borough was, therefore, not able to analyse use of force in custody, to identify trends and the effectiveness of use of force techniques.

Recommendations

4.24 Strip-searching should be more closely monitored and the reasons for its apparently disproportionate use should be addressed.

4.25 The Metropolitan Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

Physical conditions

4.26 The cells and detention rooms were mainly clean, although there were some exceptions; for example, at Hounslow there was a cell in which wet toilet paper had been thrown at a CCTV camera, probably some time ago, and not been cleaned off. Most cells contained graffiti. At Chiswick, cells had some natural light but some were cold. Toilets, washbasins, showers and booking-in areas in both suites were clean and tidy.

4.27 At Hounslow and Chiswick, cells were checked between uses. At Chiswick, we saw night staff carrying out meticulous cell checks when coming on duty, including checking for items hidden in mattresses and for ligature points. Daily and weekly health and safety checks were undertaken and recorded, although it was unclear what quarterly checks took place. Staff reported prompt action to rectify issues identified, usually within 24 hours. We found no ligature points in the cells we inspected.

4.28 All cell call bells were in working order and their use was usually explained to detainees. Call bells were responded to quickly by staff and we saw staff following up on enquiries for detainees.

4.29 During the inspection, we saw non-custody staff visiting the cells, mainly to take a detainee there or to bring him/her out. We considered that it was less likely that these officers could adequately explain cell processes to a detainee, and that the care of detainees, once booked in, should be the responsibility of custody staff alone. In addition, the duty of care and accountability for this clearly rested with custody staff who were not able to discharge these responsibilities in these circumstances.

4.30 Smoking was not allowed in any of the custody suites and there were no alternatives offered to detainees, such as nicotine replacement.

4.31 Fire alarms were tested regularly but there was no record of regular fire evacuation drills. Adequate supplies of rigid plastic handcuffs were available for use in an evacuation and were readily accessible.

Recommendations

4.32 Cells should be clean and free of graffiti.

4.33 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them.

Housekeeping point

4.34 Fire evacuation drills should be carried out and records kept.

Personal comfort and hygiene

4.35 All cells were provided with a mattress and pillow that were clean and in good condition. At Hounslow, there were plentiful stocks of blankets, and detainees could have more than one if they wanted. Hygiene packs for women detainees were available only on request. Soap, toothbrushes and other hygiene items were also in plentiful supply but we were told that detainees were not allowed to use a razor, even under supervision. This meant that male detainees could not shave before going to court. The two showers at Hounslow offered a reasonable degree of privacy to men but not to women, as they were located in areas that were not separate from the men's cells. The shower at Chiswick was poorly located and had minimal hot water output, so was not fit for purpose; the custody sergeant said that he had requested that it be repaired on more than one occasion. Only paper towels were available. In our survey, 6% of detainees who had been held at Hounslow or Chiswick said that they had been offered a shower, which was in line with the comparator but still low. Toilet paper was available only on request. Cell toilets were obscured on CCTV screens.

4.36 There was a wide range of replacement clothing available, including track suit tops and bottoms, T-shirts and plimsolls. Paper suits were not in use. Replacement underwear (for both men and women) was available at Hounslow but not at Chiswick.

Recommendation

4.37 All detainees held overnight, or who require one, should be offered a shower, be able to use it in reasonable privacy and be provided with a cotton towel.

Housekeeping points

4.38 Toilet paper should be available in each cell, and hygiene packs should be routinely offered to female detainees.

4.39 Replacement underwear should be available at all suites.

4.40 A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before attending court can do so.

Catering

4.41 A wide range of microwave meals was available and they appeared to have a reasonable calorific content. Halal and vegetarian, but not kosher, meals were available. There were no food temperature probes. Hot and cold drinks were offered at regular intervals. Custody staff had not received food hygiene training. Detainees' families could bring in food, provided that it was in the original sealed packaging. In the custody records we examined, 70% of detainees in our sample had been offered at least one meal while in custody but 30% had not been offered anything to eat, all but three of whom had been in custody for up to six hours.

Housekeeping points

4.42 A range of meals that meet all dietary needs should be available.

4.43 The temperature of microwave meals should be checked and recorded.

4.44 All custody staff should receive food handling training.

Activities

4.45 There were no reading materials available and there was no exercise yard. There were no visiting facilities and staff told us that visits were not possible.

Recommendation

4.46 Facilities should be established for detainees who are in custody for long periods to be offered some outdoor exercise.

Housekeeping points

4.47 Reading materials suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available.

4.48 Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable.

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 Custody sergeants questioned arresting officers about the reasons for arrest. There appeared to be little consideration of alternatives to custody. At Chiswick, DDOs carried out the booking-in procedures once custody had been authorised by a sergeant.

5.2 On booking-in, detainees were told that they could inform someone of their arrest, and staff facilitated telephone calls promptly. At Hounslow, we observed that detainees were permitted to make several telephone calls during their stay in custody, including informing family members of when they were to be transferred to court.

5.3 We were told that the force had a good relationship with the UK Border Agency, and immigration detainees were usually held in the custody suites for just under six hours. Between January and September 2011, 68 immigration detainees had been processed through Hounslow custody suites.

5.4 Leaflets about legal rights were available in several languages and were easily accessible on the NSPIS system. A professional telephone interpreting service was available, used through two-handset telephones, and also a face-to-face interpreting service, catering for foreign languages and sign language. We saw such services being used to inform detainees of their rights, for medical matters and for interviews. None of the suites had access to information in Braille.

5.5 Police custody suites were not used as a place of safety under Section 46 of the Children Act 1989.

5.6 All of the detainees we observed being booked in were asked about any dependency obligations. Custody staff were sympathetic when such issues were raised and assisted detainees in making alternative arrangements when needed.

5.7 The custody record system in use incorporated a pre-release risk assessment prompt for custody sergeants to complete. We observed good risk assessment processes for one vulnerable female detainee held at Chiswick, which involved Social Services in-post release care. Other detainees were offered to be taken home and the chance to contact relatives to collect them. A leaflet was provided to all detainees on release which gave details of local support services. Pre-release risk assessments had been completed in all of the custody records we analysed. They were usually basic but in one instance, there was evidence that a vulnerable detainee had been appropriately referred for help on release.

Housekeeping points

5.8 The MPS should further develop and promote alternative-to-custody approaches.

5.9 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs.

Rights relating to PACE

5.10 We observed detainees being told about the PACE codes of practice during booking in, although available copies were out of date. Solicitors were called promptly. When detainees declined the services of a solicitor, we saw staff assuring them that they could change their mind later if they wished. The duty solicitor scheme appeared to operate effectively. Reasons for declining legal advice were recorded in 76% of the custody records we examined. Detainees were able to contact and receive calls from their solicitors by telephone but privacy was limited, as the calls were made in the booking-in area. There were sufficient consultation rooms at both suites. Detainees and solicitors could easily obtain a copy of the detainee's custody record.

5.11 We observed several reviews of detention by inspectors. All but two, which had been delayed during busy periods, were on time. The records we analysed revealed a number of cases where inspectors had conducted reviews while the detainee was asleep. In these instances, there was no evidence that the detainees had then been informed of the review when they woke. Staff told us that detainees were not interviewed while under the influence of alcohol or drugs.

5.12 Family members were usually the first consideration when an AA was required for juveniles and vulnerable adults. When this was not possible, custody staff contacted Social Services, which provided a service seven days a week; however, AAs were not always available during the night for vulnerable adults at Hounslow, or for either juveniles or vulnerable adults at Chiswick. Records did not always show that AAs were present during key stages of custody. Custody sergeants told us that they often contacted Social Services for secure accommodation beds, to prevent juveniles being held in police custody overnight, but were always refused. They did not consider the use of non-secure beds for vulnerable juveniles who did not require secure accommodation but somewhere safe to stay. The force adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless otherwise deemed vulnerable.[5]

5.13 Court cut-off times were around 3pm on weekdays and 10am on Saturdays. We noted on the first day of the inspection that several detainees had been kept in custody over the weekend because they had not been able to get into court by 10am on Saturday.

5.14 We witnessed long delays in getting detainees to court in general. A new escort contract had started in August 2011 and escort providers and custody staff alike reported undue delays under the operation of the contract. At both custody suites we noted that escorting vehicles did not arrive until mid-morning to convey detainees to court for 9am hearings. A further consequence of the new contract was the daily occurrence of prisoners being locked out of HM Prison Service establishments due to escort vehicles arriving at the sites after 7pm, leading to police cells being used unnecessarily for prisoners. Escorting staff reported that they often had to wait several hours in court cells or in vans while spaces were found in police cells, sometimes as far away as Birmingham and Manchester. We came across two instances where young offenders had waited on vans for almost three hours while a space was found. This had led to escorting staff driving for over 10 hours in some cases (see also paragraph 4.1).

[5] Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

5.15 The handling and processing of DNA and forensic samples were well managed and there was an effective process for prompt collection of samples.

Recommendations

5.16 Appropriate adults should be available without undue delay to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.

5.17 The MPS should continue to liaise with Serco Wincanton to resolve recent difficulties with escort arrangements, so that detainees are not inappropriately held in police custody, subjected to long periods in cellular vehicles or unreasonably delayed in their arrival at court.

5.18 The MPS should liaise with the local court to achieve more reasonable cut-off times for Saturday morning courts.

Housekeeping points

5.19 Up-to-date copies of PACE codes of practice should be provided.

5.20 Detainees should be able to make telephone calls to legal representatives in private.

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

Rights relating to treatment

5.22 Detainees were not routinely told how to make a complaint about their treatment, in accordance with the Independent Police Complaints Commission 2010 statutory guidance. Complaints were rarely recorded while a detainee was in custody. At Hounslow, detainees wishing to complain were advised to attend the enquiry desk on their release, to see the inspector; at Chiswick, they were advised to attend Hounslow police station for this purpose. There was no process for following up these initial complaints if the detainee was remanded in custody.

5.23 The borough received information on complaints but there was no breakdown of those which related to custody.

Recommendation

5.24 Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody; data about complaints should be monitored.

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 Primary health services were provided by FMEs. There was a contract between individual FMEs and the Police Authority (with the intention that the services were provided for the Commissioner within the Metropolitan Police Forensic Medical Service) but it was not specific in relation to response times, appraisals or professional development. FMEs told us that they were expected to maintain their own professional development, in line with the requirements of their professional bodies, but there was limited oversight of this by the CJD.

6.2 During the inspection, there were no female FMEs on the rota, and custody staff seemed unsure what they would do if a female detainee requested to see a female doctor. Doctors told us that a telephone interpreting service was used for detainees who could not speak or understand English.

6.3 The clinical room at Chiswick was shabby and dirty, with thick dust on the top of cupboards and a broken bin. The walls were damaged and the couch was dirty. The room at Hounslow was small, cramped and cluttered. We found out-of-date equipment and forensic sampling kits in the cupboards at Chiswick, which were thrown away when we brought them to the attention of staff. No temperature checks were undertaken on the drug refrigerators in either room and we found surgical glue that was over a year out of date in the refrigerator in Chiswick; this was also discarded when we told staff about it. The refrigerator at Hounslow was overstocked and had clearly not been maintained at the correct temperature, as there was water at the bottom of it. None of the sharps boxes or the pharmaceutical waste bins had been signed and dated on start of use and we found sharps in the pharmaceutical waste bin at Hounslow.

6.4 The management of medications was of concern. In Chiswick, there was a secure cabinet in the room, the key to which was kept in a separate safe. However, it was overstocked and there was no audit of Schedule 4 and 5 medications (Misuse of Drugs Act classification), despite this being MPS policy. We found over 330 5 mg of diazepam tablets in the cabinet, some in loose foils and some in overfull boxes, containing tablets with different expiry dates, and also over 260 dihydrocodeine tablets. We found paracetamol tablets in an unlocked cupboard.

6.5 The situation at Hounslow was similar, although the key to the drug cupboard there was held with the main custody keys, so the cupboard was accessible to several people. The cupboard contained over 130 dihydrocodeine tablets in overfull boxes, and an open glyceryl trinitrate spray (for the treatment of angina) which may have been used previously. There was also a 'stock cupboard' containing large quantities of a variety of medications. There was no record of stock control. We brought our findings to the attention of Forensic Medical Services in the MPS CJD at the earliest opportunity (see main recommendation 2.19).

6.6 At Brentford, we found a large evidence bag of stock medications in a cupboard, dating back about six months; it was unclear why the bag was there and staff seemed unaware of it. We spoke to an FME, who said that he carried his own stock of medications around in an unlocked bag, which also contravened MPS policy.

6.7 All the suites had defibrillators held behind the custody desks and rescu-vacs and lifepack masks were available. Staff had received resuscitation training. The defibrillators were checked each night as part of the documented equipment checks. First-aid kits were also available but the contents were not standardised and some items had recently become out of date.

Recommendation

6.8 There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and able to be used to take forensic samples.

Patient care

6.9 On arrival, detainees were asked whether they wished to see a doctor. The FMEs for Hounslow and Chiswick also covered at least four other police stations, as well as Brentford, when it was used. Staff told us that it was sometimes difficult to get an FME to attend, and that they had sometimes resorted to calling an ambulance to ensure prompt attendance to a detainee's health needs. Analysis by the MPS CJD revealed that about 10% of detainees had required or requested an FME since the beginning of 2011, for which only 21% of the records clearly indicated when the FME had arrived, with an average wait of two hours. In our analysis of custody records, only five out of 30 records contained a request to see an FME. Four had seen an FME; the longest wait had been 41 hours but the average had been two hours 40 minutes. We found an example of a detainee for whom injuries obtained during his arrest and restraint had been noted in the custody record but an FME not been requested by either the detainee or the custody staff. In our survey, 40% of detainees said that they had seen an FME, 29% of whom rated the care they received as good or very good, which was in line with the comparator.

6.10 In our survey, 29% of respondents who were on prescribed medication said that they had been able to continue taking it while in custody. However, for those with immediate symptoms of substance use withdrawal, only 22% said that they had received relief of their symptoms. Substance use staff told us that it was rare for detainees on a recognised maintenance programme to be able to receive their medication while in custody.

6.11 Medications left by the FME for later administration by custody staff were attached to custody records. In Hounslow, these were kept behind the custody desk but in Chiswick they were on the desk and so easily accessible to detainees. Staff made a note on NSPIS to remind themselves when medications were due.

6.12 The FMEs used NSPIS to record their clinical findings, and most also kept their own contemporaneous records. There was no evidence that detainees had consented to the sharing of information. The FME contract made it clear that all clinical records made by the FME remained subject to their control and to the normal regulations and statutory provisions governing medical records, as well as the related principles of good medical practice in record-keeping promulgated by the General Medical Council. FMEs were responsible for the retention and secure storage of records but there was no consistency between the FMEs as to how they were stored or for how long.

Recommendations

6.13 The response times of forensic medical examiners (FMEs) should be subject to monitoring and action taken as required to ensure that there are no unacceptable delays for detainees in receiving the services of a health professional.

6.14 FMEs should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott principles.

Housekeeping point

6.15 Prescribed medications should be kept securely and not within the reach of detainees.

Substance use

6.16 Crime Reduction Initiatives (CRI), a third-sector organisation and part of the local drug intervention programme (DIP), provided substance use services to both custody suites from 9am to 9pm each weekday. They carried out assessments on all adult detainees who had committed a trigger offence and others who requested to see them. They offered one-to-one support and access to prescribing services. For those under the age of 18 and those with alcohol issues, they signposted or referred detainees to local projects as appropriate. If detainees required the services out of hours, custody staff made an appointment for the detainee with CRI staff using a simple diary system.

6.17 Clean needles and syringes were not available in the custody suite, although we were told that there were places nearby where they could be obtained.

Housekeeping point

6.18 Injecting drug users who are being released into the community should be offered clean needles and syringes.

Mental health

6.19 The custody suites were not used as a place of safety for section 136 assessments. The section 136 assessment suite was located at West Middlesex Hospital, and in the previous 12 months, 167 detainees from the borough Hounslow had been taken there.

6.20 There was an enthusiastic mental health police liaison officer in post, who had established excellent working arrangements with West London Mental Health Trust. There were regular meetings, at which the circumstances of any patient or care worker who had required police intervention were discussed, as were all section 136 admissions. The liaison officer provided a visible presence on the acute psychiatric wards at the Trust. There were police liaison and assessment suite protocols in place. Staff at the assessment suite were positive about the role that the police liaison officer had played in improving the management of section 136 detainees.

6.21 The police liaison officer had developed an information-sharing agreement, so was able to provide the Trust with collateral information about new patients, and had been instrumental in developing care plans for specific patients in the community in the event of them being arrested.

Good practice

6.22 *The mental health police liaison officer had established a good working relationship with the West London Mental Health Trust; this model of work could be easily repeated in other forces/boroughs.*

7. Summary of recommendations

Main recommendations

To the Metropolitan Police Service

7.1 All staff required to work in custody should be adequately trained, including refresher training. (2.17)

7.2 A comprehensive risk assessment should in all instances be completed, and the management of risk should be consistent with the risk management plan. (2.18)

7.3 There should be safe pharmaceutical stock management; all medications should be stored safely and securely in line with national best practice and local policy. (2.19)

Recommendations

To the Metropolitan Police Service

Strategy

7.4 Arrangements for the daily quality assurance of custody records through dip-sampling should be put in place when the custody manager is absent. (3.16)

Treatment and conditions

7.5 Staff should receive up to date awareness training on child protection and safeguarding. (4.7)

7.6 There should be clear policies and procedures to meet the diverse needs of detainees, including those associated with faith, and those of women, juveniles and detainees with disabilities; custody staff should be trained to recognise these differing needs. (4.8)

7.7 Dip-sampling of custody records should include scrutiny of prisoner escort record forms, so that the discrepancies can be monitored and addressed. (4.16)

7.8 Closed-circuit television (CCTV) systems should be updated to improve the quality and coverage of the images and to facilitate their retrieval. CCTV quality assurance should be recorded, with a clear audit trail. (4.17)

7.9 All custody staff should carry anti-ligature knives. (4.18)

7.10 Custody sergeants and detention officers should receive their handover together. (4.19)

7.11 Strip-searching should be more closely monitored and the reasons for its apparently disproportionate use should be addressed. (4.24)

7.12 The Metropolitan Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.25)

7.13 Cells should be clean and free of graffiti. (4.32)

7.14 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.33)

7.15 All detainees held overnight, or who require one, should be offered a shower, be able to use it in reasonable privacy and be provided with a cotton towel. (4.37)

7.16 Facilities should be established for detainees who are in custody for long periods to be offered some outdoor exercise. (4.46)

Individual rights

7.17 Appropriate adults should be available without undue delay to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.16)

7.18 The MPS should continue to liaise with Serco Wincanton to resolve recent difficulties with escort arrangements, so that detainees are not inappropriately held in police custody, subjected to long periods in cellular vehicles or unreasonably delayed in their arrival at court. (5.17)

7.19 The MPS should liaise with the local court to achieve more reasonable cut-off times for Saturday morning courts. (5.18)

7.20 Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody; data about complaints should be monitored. (5.24)

Health care

7.21 There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and able to be used to take forensic samples. (6.8)

7.22 The response times of forensic medical examiners (FMEs) should be subject to monitoring and action taken as required to ensure that there are no unacceptable delays for detainees in receiving the services of a health professional. (6.13)

7.23 FMEs should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott principles. (6.14)

Housekeeping points

Strategy

7.24 Independent Police Complaints Commission 'learning the lessons' briefings should be more easily accessible and staff should be reminded to use them. (3.17)

Treatment and conditions

7.25 Fire evacuation drills should be carried out and records kept. (4.34)

7.26 Toilet paper should be available in each cell, and hygiene packs should be routinely offered to female detainees. (4.38)

7.27 Replacement underwear should be available at all suites. (4.39)

7.28 A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before attending court can do so. (4.40)

7.29 A range of meals that meet all dietary needs should be available. (4.42)

7.30 The temperature of microwave meals should be checked and recorded. (4.43)

7.31 All custody staff should receive food handling training. (4.44)

7.32 Reading materials suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available. (4.47)

7.33 Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable. (4.48)

Individual rights

7.34 The MPS should further develop and promote alternative-to-custody approaches. (5.8)

7.35 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.9)

7.36 Up-to-date copies of PACE codes of practice should be provided. (5.19)

7.37 Detainees should be able to make telephone calls to legal representatives in private. (5.20)

7.38 Detainees should be informed of any reviews carried out while they were sleeping, and a record to this effect should be made in the custody record. (5.21)

Health care

7.39 Prescribed medications should be kept securely and not within the reach of detainees. (6.15)

7.40 Injecting drug users who are being released into the community should be offered clean needles and syringes. (6.18)

Good practice

Strategy

7.41 The decision to allow detention officers to book in a limited number of detainees in straightforward cases under the supervision of the custody sergeant, until formal implementation of Operation Herald, was a sensible approach, allowing staff to maintain and develop the skills learned from the training course. (3.18)

Health care

7.42 The mental health police liaison officer had established a good working relationship with the West London Mental Health Trust; this model of work could be easily repeated in other forces/boroughs. (6.22)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Karen Dillon	HMIP inspector
Peter Dunn	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Roger James	CQC inspector
Laura Nettleingham	HMIP researcher
Rachel Murray	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Hounslow, 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 23rd September 2011. A list of potential respondents to have passed through Hounslow or Chiswick police stations was created, listing all those who had arrived from Feltham, Brentford or Uxbridge Magistrates' court within the previous three months.[6]

Selecting the sample

On the day, the questionnaire was offered to 35 respondents; one survey was not returned. All of those sampled had been in custody within the previous three months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. 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, 34 (97%) respondents completed and returned their questionnaires.

[6] 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 three 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.

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 45 police areas since April 2008.

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

Summary

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

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

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

Police Custody Survey results

Section 1: About you

Q2 Which police station were you last held at?

Hounslow (24)
Chiswick (10)

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	5 (15%)
17-21 years	1 (3%)	*50-59 years*	0 (0%)
22-29 years	15 (44%)	*60 years or older*	0 (0%)
30-39 years	13 (38%)		

Q4 Are you:

Male	34 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	15 (44%)
White - Irish	0 (0%)
White - other	2 (6%)
Black or black British - Caribbean	4 (12%)
Black or black British - African	4 (12%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	6 (18%)
Asian or Asian British - Pakistani	1 (3%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	2 (6%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	9 (29%)
No	22 (71%)

Q7 What, if any, is your religion?

None	4 (13%)
Church of England	13 (41%)
Catholic	3 (9%)
Protestant	0 (0%)
Other Christian denomination	1 (3%)
Buddhist	0 (0%)

Hindu 3 (9%)
Jewish 0 (0%)
Muslim 5 (16%)
Sikh 3 (9%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 32 (97%)
Gay/lesbian/homosexual 1 (3%)
Bisexual 0 (0%)

Q9 Do you consider yourself to have a disability?
Yes 2 (6%)
No 31 (94%)

Q10 Have you ever been held in police custody before?
Yes 28 (82%)
No 6 (18%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 10 (29%)
More than 24 hours, but less than 48 hours (2 days) 15 (44%)
More than 48 hours (2 days), but less than 72 hours (3 days) 5 (15%)
72 hours (3 days) or more 4 (12%)

Q12 Were you told your rights when you first arrived there?
Yes 26 (76%)
No 5 (15%)
Don't know/can't remember 3 (9%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 17 (53%)
No 12 (38%)
I don't know what this is/I don't remember 3 (9%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 17 (53%)
I was offered a tracksuit to wear 8 (25%)
I was offered an evidence/paper suit to wear 5 (16%)
*I was **only** offered a blanket* 1 (3%)
Nothing 1 (3%)

Q15 Could you use a toilet when you needed to?
Yes 32 (94%)
No 2 (6%)
Don't know 0 (0%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 13 (39%)

No 20 (61%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	10 (30%)	8 (24%)	15 (45%)
Ventilation/air quality	6 (19%)	7 (22%)	19 (59%)
Temperature	5 (16%)	3 (9%)	24 (75%)
Lighting	14 (44%)	4 (13%)	14 (44%)

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

Yes 15 (50%)
No 15 (50%)

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

Yes 8 (24%)
No 26 (76%)

Q20 Were you held overnight?

Yes 32 (94%)
No 2 (6%)

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

Not held overnight 2 (6%)
Pillow 16 (47%)
Blanket 23 (68%)
Nothing 4 (12%)

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

Not held overnight/did not get any bedding 6 (20%)
Yes 14 (47%)
No 10 (33%)

Q23 Were you offered a shower at the police station?

Yes 2 (6%)
No 31 (94%)

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

Yes 0 (0%)
No 34 (100%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	21 (66%)	11 (34%)
Drink?	24 (75%)	8 (25%)

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

Very good	*Good*	*Neither*	*Bad*	*Very Bad*	*N/A*
0 (0%)	2 (6%)	4 (12%)	8 (24%)	19 (56%)	1 (3%)

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

I did not have any food or drink	1 (4%)
Yes	11 (39%)
No	16 (57%)

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	9 (26%)
I was allowed to smoke	1 (3%)
I was offered a nicotine substitute	1 (3%)
I was not offered anything to cope with not smoking	23 (68%)

Q29 Were you offered anything to read?

Yes	1 (3%)
No	32 (97%)

Q30 Was someone informed of your arrest?

Yes	10 (29%)
No	17 (50%)
I don't know	2 (6%)
I didn't want to inform anyone	5 (15%)

Q31 Were you offered a free telephone call?

Yes	19 (56%)
No	15 (44%)

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

My telephone call was not denied	20 (61%)
Yes	2 (6%)
No	11 (33%)

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

	Yes	*No*
Who was taking care of your children	6 (21%)	23 (79%)
Contacting your partner, relative or friend	15 (54%)	13 (46%)
Contacting your employer	6 (25%)	18 (75%)
Where you were going once released	8 (33%)	16 (67%)

Q34 Were you offered free legal advice?

Yes	29 (85%)
No	5 (15%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	5 (16%)
Yes	22 (69%)
No	5 (16%)

Q36 Were you interviewed by police about your case?

Yes	33 (100%)
No	0 (0%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	0 (0%)
Yes	23 (68%)
No	11 (32%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	14 (42%)
Yes	3 (9%)
No	16 (48%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	14 (44%)
Yes	1 (3%)
No	17 (53%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	21 (66%)
No	11 (34%)

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

Yes	13 (39%)
No	20 (61%)

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

I have not been victimised	20 (61%)	*Because of your crime*	4 (12%)
Insulting remarks (about you, your family or friends)	5 (15%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	2 (6%)	*Because you have a disability*	0 (0%)
Sexual abuse	1 (3%)	*Because of your religion/religious beliefs*	1 (3%)
Your race or ethnic origin	1 (3%)	*Because you are from a different part of the country than others*	2 (6%)
Drugs	3 (9%)		

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

Yes	24 (73%)
No	7 (21%)
I wasn't handcuffed	2 (6%)

Q45 Were you restrained while in the police custody suite?

Yes	4 (13%)
No	27 (87%)

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

Yes	5 (15%)
No	28 (85%)

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

Yes	4 (12%)
No	30 (88%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
0 (0%)	6 (19%)	15 (47%)	7 (22%)	1 (3%)	3 (9%)

Section 4: Health care

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

Yes	11 (32%)
No	20 (59%)
Don't know	3 (9%)

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

	Yes	*No*
Doctor	13 (39%)	20 (61%)
Nurse	0 (0%)	23 (100%)
Paramedic	2 (8%)	23 (92%)

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

Yes	7 (21%)
No	19 (58%)
Don't know	7 (21%)

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

Yes	10 (30%)
No	23 (70%)

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

Not taking medication	23 (70%)
Yes	3 (9%)
No	7 (21%)

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

Yes	19 (56%)
No	15 (44%)

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	15 (44%)
Yes	7 (21%)
No	12 (35%)

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

I didn't have any drug/alcohol problems	15 (45%)
Yes	4 (12%)
No	14 (42%)

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*
20 (59%)	0 (0%)	4 (12%)	1 (3%)	4 (12%)	5 (15%)

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

Yes	12 (39%)
No	19 (61%)

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

Yes	4 (13%)
No	27 (87%)

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	27 (87%)
Yes	0 (0%)
No	4 (13%)

Prisoner survey responses for Hounslow Police 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

		Hounslow police 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		34	1605
SECTION 1: General information			
3	Are you under 21 years of age?	**2%**	**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)?	**50%**	**30%**
6	Are you a foreign national?	**29%**	**14%**
7	Are you Muslim?	**15%**	**11%**
8	Are you homosexual/gay or bisexual?	**2%**	**2%**
9	Do you consider yourself to have a disability?	**6%**	**20%**
10	Have you been in police custody before?	**82%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**70%**	**66%**
12	Were you told your rights when you first arrived?	**76%**	
13	Were you told about PACE?	**53%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**55%**	
15	Could you use a toilet when you needed to?	**94%**	**90%**
16	If you used the toilet, was toilet paper provided?	**40%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**31%**	**32%**
17b	Ventilation/air quality?	**19%**	**22%**
17c	Temperature?	**15%**	**15%**
17d	Lighting?	**45%**	**44%**
18	Was there any graffiti in your cell when you arrived?	**50%**	**55%**
19	Did staff explain the correct use of the cell bell?	**24%**	**22%**
20	Were you held overnight?	**94%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**87%**	
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**58%**	
23	Were you offered a shower?	**6%**	**9%**
24	Were you offered a period of outside exercise?	**0%**	**6%**
25a	Were you offered anything to eat?	**66%**	**81%**
25b	Were you offered anything to drink?	**75%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**6%**	**10%**
27	Was the food/drink you received suitable for your dietary requirements?	**40%**	**44%**

Key to tables

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For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**6%**	**7%**
29	Were you offered anything to read?	**2%**	**13%**
30	Was someone informed of your arrest?	**30%**	**43%**
31	Were you offered a free telephone call?	**56%**	**49%**
If you were denied a free telephone call:			
32	Was a reason given?	**16%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**21%**	**14%**
33b	Contacting your partner, relative or friend?	**54%**	**53%**
33c	Contacting your employer?	**26%**	**20%**
33d	Where you were going once released?	**33%**	**31%**
34	Were you offered free legal advice?	**86%**	
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**82%**	
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**68%**	
38	Was an appropriate adult present when you were interviewed?	**14%**	
39	Was an interpreter present when you were interviewed?	**4%**	
SECTION 3: Safety			
41	Did you feel unsafe?	**34%**	**39%**
42	Has another detainee or a member of staff victimised you?	**40%**	
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**15%**	
43b	Physical abuse (being hit, kicked or assaulted)	**6%**	
43c	Sexual abuse	**2%**	
43d	Your race or ethnic origin	**2%**	
43e	Drugs	**8%**	
43f	Because of your crime	**12%**	
43g	Because of your sexuality	**0%**	
43h	Because you have a disability	**0%**	
43i	Because of your religion/religious beliefs	**2%**	
43j	Because you are from a different part of the country than others	**6%**	
44	Were your handcuffs removed on arrival at the police station?	**78%**	**74%**
45	Were you restrained whilst in the police custody suite?	**13%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**15%**	**24%**
47	Were you told how to make a complaint about your treatment?	**12%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**19%**	

Key to tables

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	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**32%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**40%**	**47%**
51b	Nurse	**0%**	**20%**
	Percentage seen by either a doctor or a nurse	**40%**	**53%**
51c	Paramedic	**8%**	**4%**
52	Were you able to see a health care professional of your own gender?	**21%**	**27%**
53	Did you need to take any prescribed medication when you were in police custody?	**31%**	**45%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**29%**	**38%**
55	Did you have any drug or alcohol problems?	**56%**	**54%**
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?	**36%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**22%**	
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**29%**	**29%**
59	Did you have any specific physical health care needs?	**39%**	**33%**
60	Did you have any specific mental health care needs?	**13%**	**25%**
For those who had any mental healthcare needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	