Report on a follow-up inspection visit to police custody suites in the Metropolitan Police Service Borough Operational Command Unit of Tower Hamlets

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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. We also reviewed progress against the recommendations made after our visit to the BOCU in July 2009.

There had been clear improvements made in custody provision since the initial inspection, but there was still room for further improvement. There was a recently appointed custody manager, managing permanent custody staff. This arrangement provided the opportunity for a more effective delivery of the custody function. However, there were still no quality assurance arrangements in place to systematically review custody records and 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. There was good visibility of senior management in custody.

The custody estate was much improved with both suites in relatively good order. Cells were generally clean and cell inspections found no ligature points. Interactions with detainees were appropriate but there was still limited attention to an awareness of diversity issues. Risk assessment was generally thorough, but delays were leading to detainees being held in handcuffs for too long. Our own and management data indicated a high use of strip searching of detainees.

An appropriate balance was maintained between progressing cases and the rights of individuals, and the Police and Criminal Evidence Act (PACE) was adhered to. There needed to be greater focus on the quality of pre-release risk assessments. Appropriate adult provision had improved but was still inadequate, and the lack of local authority PACE beds led to some juveniles being unnecessarily detained in police custody overnight. Arrangements for managing DNA and forensic samples were improved although some issues remained. Whilst detainees were not routinely informed how to make a complaint, arrangements for taking them were improved and there was good analysis of them taking place.

Overall primary healthcare services had improved greatly; the recruitment of nurses having a positive impact. There were still areas for improvement in infection control and monitoring arrangements for primary care and nursing services. There were good links with drugs services provided by the local NHS. Diversion services for detainees with mental health issues needed to be improved but it was positive that custody was not used as a place of safety under the Mental Health Act.

Overall, custody provision in Tower Hamlets was much improved from the previous inspection.

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

This report sets out a small number of recommendations that we hope will assist the MPS and MPA to improve the facilities further.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

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January 2012

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*[2] about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.

2.2 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.

2.3 This announced follow-up inspection was conducted at police custody suites in the MPS borough operational command unit (BOCU) of Tower Hamlets. We previously inspected custody provision in the borough in late July 2009. We examined force-wide and BOCU custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites, and also reviewed progress against the recommendations made in the previous inspection report. There were still two custody suites, operating 24 hours a day: Bethnal Green, which had 19 cells, and Limehouse, with seven cells. In the period from 1 January 2011 to 18 November 2011, custody suites in the BOCU had held 8,684 detainees. In the same period, 111 immigration detainees had been held.

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

Strategic overview

2.5 We made eight recommendations in this area after our inspection in July 2009. Of these, 4 had been achieved, 2 partially achieved and 2 not achieved.

2.6 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.

2.7 The BOCU saw custody as a priority area, which was evidenced by the investment in permanent staffing, although this approach now appeared to be under threat. Staff were trained to work in custody, although refresher training had lapsed. A permanent full-time custody manager had recently been appointed.

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

2.8 Quality assurance mechanisms including dip sampling of custody records needed to be improved but partnership relationships were mainly well developed, although some attention to mental health was needed.

Treatment and conditions

2.9 We made 22 recommendations in this area after our inspection in July 2009. Of these, 5 had been achieved, 5 partially achieved, 10 not achieved and 2 were no longer relevant.

2.10 Staff interactions with detainees were respectful and staff demonstrated a good level of care for the welfare of detainees. Awareness of diversity issues was an issue that needed to be addressed as a priority. Professional interpreting services were used when needed. There were issues with privacy.

2.11 Risk assessments were carried out when detainees arrived in custody and the quality of these were generally good. Risk management arrangements were mainly proportionate but there were exceptions. Handovers between shifts took place but some arrangements needed to be improved. Non-custody police staff had access to detainees in cells. There was no monitoring of use of force. The use of strip-searching was high, and handcuffs were not always promptly removed on arrival in custody.

2.12 The physical conditions of the custody suites had improved. Cells were clean and there was little graffiti. We found no ligature points in cells. Closed-circuit television (CCTV) equipment was poor. Detainees were not routinely told how to use cell call bells but these were responded to promptly.

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

Individual rights

2.14 We made 20 recommendations in this area after our inspection in July 2009. Of these, 10 had been achieved, 3 partially achieved, 5 not achieved and 2 no longer relevant.

2.15 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 now good.

2.16 Legal assistance was offered. Staff made calls to notify someone of the detainee's arrest, although this was not always noted, and free telephone calls were facilitated. 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, although the quality of these varied.

[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.

2.17 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 restricted options available to provide an AA out of hours and for vulnerable adults. Juveniles who could not be bailed were routinely held in police custody overnight.

2.18 Detainees were not routinely told how to make a complaint but the arrangements for taking complaints were reasonable.

Health care

2.19 We made 17 recommendations in this area after our inspection in July 2009. Of these, 8 had been achieved, 4 partially achieved and 5 not achieved.

2.20 Primary health services were good but monitoring needed to be improved. Nurse-led provision was now in place supported by forensic medical examiners (FMEs) on a rota. Response times were good. Governance arrangements were in place for nurses but needed improvement for FMEs.

2.21 Medicines management arrangements were good. Medical rooms were well equipped but some were grubby. 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. Governance of mental health services needed to be improved but detainees were not held under section 136 of the Mental Health Act 1983.[4]

Main recommendations

2.22 Arrangements for the quality assurance of custody records and associated issues through dip-sampling should be introduced and recorded, with a clear audit trail.

2.23 There should be a clearer focus on ensuring that the needs of all detainees are addressed, including juveniles, women, those with disabilities and members of ethnic minorities.

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

[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 Strategic leadership for the custody function was provided by the BOCU commander. Management arrangements for custody were better than we normally see in the MPS and much improved from the last inspection. At the senior management team (SMT) level, there was a chief inspector lead for criminal justice, who line-managed a recently appointed full-time dedicated custody manager. The custody manager line-managed permanent custody sergeants. Visibility of the SMT in custody was evident.

3.2 Staffing within custody suites was adequate and comprised permanent sergeants, supported by permanent designated detention officers (DDO), 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 by police constable (PC) gaolers for DDOs. These arrangements were better than we normally see in the MPS and much improved from our previous inspection.

3.3 Partnership arrangements were described as good, with the BOCU commander chairing the community safety partnership meeting. The deputy commander represented the BOCU on the joint Local Safeguarding Children Board with the borough of Hackney. Relationships with the Crown Prosecution Service were good, with a prosecutor based at Bethnal Green police station and pre-arranged advice surgeries.

3.4 There was a daily meeting between the custody manager and the CJ chief inspector to discuss a range of custody performance issues, which included constant watches and successful interventions. This meeting preceded the senior management team (SMT) daily management meeting, where the CJ chief inspector raised issues arising from the meeting with the custody manager. Custody issues were also discussed at a formal monthly meeting, chaired by the CJ chief inspector and attended by the custody manager. The CJ chief inspector could escalate custody issues formally at the monthly SMT meeting. Custody near-miss reports were an agenda item at the quarterly health and safety meeting. There was no custody user meeting, and therefore no forum for practitioners to discuss issues.

3.5 All custody sergeants and DDOs had received training before going into custody. Yearly mandatory training was provided but no custody refresher training. PC gaolers received an online training package.

3.6 The BOCU managed risks associated with the custody function through the template provided by the MPS CJD. This risk register was managed by the custody manager and monitored by the Criminal Justice (CJ) chief inspector, with an escalation process to the SMT.

3.7 There were processes for dealing with adverse incidents, termed ‘successful interventions’. A form was generated from the computer system in custody, and sent to the custody manager and the CJD. Successful interventions and other custody-related circulations were disseminated to staff by the custody manager by email. However, there was no custody-specific link on the BOCU intranet pages, and some staff were unclear on how to access such information.

3.8 There was an established ICV scheme. ICVs told us that they were admitted to custody centres quickly and that staff were courteous and professional. They commented positively on the improvements to and professionalism of custody provision since the implementation of permanent staffing. They cited a recent lack of engagement from the BOCU, in regard to a lack of representation at panel meetings, but were confident that this would be addressed by the new custody manager.

3.9 No dip-sampling of custody records or CCTV was taking place – a weakness which had been highlighted in the inspection report in 2009 (see main recommendation 2.22).

Housekeeping point

3.10 A custody web page on the force intranet with links to relevant newsletters and other custody information should be developed.

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 arrived at the custody suites in cars and vans. Those we inspected were clean.

4.2 Custody staff interacted with detainees in a friendly and professional manner, often using their first names. Staff had mainly volunteered to work in custody and this showed in their approach, which was thoroughly professional. However, staff used a `one size fits all` approach to booking in detainees, with limited understanding of the different needs of a diverse population. Women were told they could speak to a female officer but otherwise there was no specific provision for female detainees who might be vulnerable (see main recommendation 2.23).

4.3 Staff had not received any recent awareness training in child protection issues. They told us that they would deal with children and young people in an age-proportionate manner – for example, by putting juveniles in detention rooms, which at Bethnal Green were situated directly opposite the custody desk. However, we saw a 15-year-old boy being brought into the Bethnal Green custody suite in school uniform and handcuffed, having been arrested on his way to school for a minor offence. He remained handcuffed, with his hands behind his back, in the waiting area for approximately 45 minutes before being booked in, even though he was compliant and had been brought to the station in a double-crewed car. Despite the prompt attendance of his mother, he was kept in a cell for several hours before being interviewed.

4.4 The booking-in process was undertaken differently across shifts and between suites. DDOs had been trained to carry out the administrative part of the process, but not all custody sergeants were allowing this to happen, instead continuing to do so themselves. Some DDOs who were booking in were new to the task and were slow, resulting in delays. This could result in long delays in handcuffs being removed (see section on use of force).

4.5 None of the cells at either suite had been adapted for detainees with disabilities. There were no hearing loops and there was no information in Braille. At Limehouse, a custody sergeant we spoke to was aware of the particular needs of transgender detainees in relation to searching.

4.6 There were prayer mats, a Qur'an and a Bible available at Bethnal Green, although they were poorly stored. The direction of Mecca was not indicated in the cells; a compass was available for this purpose but it was broken. At Limehouse, there was a box containing prayer mats and several copies of the Qur'an. There were no other holy books available, and no compass.

4.7 Booking-in desks were at floor level at both suites. However, there was a lack of privacy in the booking-in area at both suites, particularly at Bethnal Green, where on one day during the inspection we observed 14 non-custody staff in this area. Conversations among staff, detainees and solicitors, and also telephone conversations, were easily overheard, which could have inhibited vulnerable detainees from disclosing important information. At Limehouse, we observed a DDO and custody sergeant booking in two detainees simultaneously, one of whom was a pregnant woman with learning difficulties. At the same time, a detainee in custody was being bailed and a conversation about his family situation was taking place between him,

his solicitor and the arresting officer. This potential breach of confidentiality could have been avoided by offering the use of the vacant consultation room. On the previous day at Limehouse, we had observed the custody sergeant on duty managing the booking-in area in a way that maximised privacy well.

Recommendation

4.8 Arrangements in booking-in areas should allow for private communication between detainees, staff and legal representatives.

Housekeeping point

4.9 Items used for religious observance should be appropriately stored and a reliable means of indicating the direction of Mecca should be provided.

Safety

4.10 Risk assessments were mainly methodical, and practice had improved since our last inspection. This was borne out by our observations and analysis of custody records. The custody records we examined indicated whether the detainee had been in police detention for the first time. Police National Computer (PNC) warning markers about previously identified risks were automatically flagged by the national strategy for police information systems (NSPIS) custody system, and custody sergeants and DDOs knew how to add new markers when necessary. Our custody record analysis found that intelligence was generally used to inform risk assessments. Risk management was reasonable, proportionate and dynamic, with reassessment undertaken when appropriate.

4.11 At both suites, all communal areas and many cells were covered by CCTV, although this was old and some screens were of poor quality, particularly at Limehouse. The '4-Rs' mnemonic about rousing techniques was displayed on cell doors at both suites and staff were clear about the need to obtain responses from detainees subject to rousing checks.

4.12 The frequency of strip-searching was high. In our custody record analysis, over a third of the sample had been strip-searched. Data supplied by the CJD indicated that 8.4% of all detainees held in the year to date had been strip-searched. This was a risk averse approach and the force told us this reflected the high number of detainees with drug related issues.

4.13 Our inspection of person escort records (PERs) and the corresponding custody records showed that concerns about self-harm arising from risk assessments and the PNC were recorded on PERs. In most instances, the information in the PER was consistent with the custody record. Some PERs were illegible and all were stored untidily, which would make quality assurance checks on PER completion difficult to complete.

4.14 Custody sergeants and DDOs had separate handovers between shifts, which could have resulted in essential information about risk not being passed on. All custody staff carried anti-ligature knives.

Recommendations

4.15 Defective or unsuitable CCTV monitors at Limehouse should be replaced.

4.16 The use of strip searching should be monitored and any potential over-use investigated and corrected.

4.17 Shift handovers should take place jointly between the outgoing and incoming shifts and include designated detention officers.

Housekeeping point

4.18 Custody sergeants should carry out regular quality checks of person escort records, ensuring that they are legible and are retained with the custody record.

Use of force

4.19 Most detainees arrived at Bethnal Green in handcuffs, regardless of their compliance, and these were not removed until the detainee came before the custody sergeant – a length of time which varied, depending on how busy the custody suite was, but could be as long as 70 minutes. At Limehouse, those detainees who arrived in handcuffs had them removed at the start of the booking-in process, when it was judged safe to do so.

4.20 Data about use of force in custody were not collated at a local or force-wide level. Officers and staff recorded use of force in their custody records and police officers recorded it in their evidential pocket notebooks. We were told that if force was used in the custody area, a detainee would normally be seen by a health care professional soon afterwards. Staff received annual refresher training in unarmed defence.

Recommendations

4.21 Handcuffs should only be used when necessary, justifiable and proportionate, and they should be removed as soon as possible after arrival at the custody suite.

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

Physical conditions

4.23 The physical conditions at both suites had improved considerably. The Bethnal Green custody suite was in a good condition, clean and airy, although some cell floors had ingrained dirt which could not be removed by normal daily cleaning. Limehouse was also clean and well maintained, other than the floors, which were pitted and uneven, making thorough cleaning difficult. At both suites, all cells were cleaned at least once a day. There was little graffiti, except at Limehouse, where there was graffiti etched into the floor in some cells.

4.24 There were three taped interview rooms at Bethnal Green, one of which had been out of service for about two weeks at the time of the inspection. All three contained old furniture and damaged walls, and were littered with rubbish. During the inspection, a second tape interview room was taken out of service owing to a faulty tape machine. This put pressure on the last remaining interview room and led to long delays in processing detainees. The interview rooms at Limehouse were satisfactory.

4.25 Custody staff carried out and recorded daily health and safety and cell maintenance checks. However, it was unclear what regular cell checks were taking place in either suite at other intervals.

4.26 We saw cell call bells being answered reasonably promptly at both suites, although we saw several detainees placed in cells without having the use of call bells explained to them. It was normal practice for cell keys to be passed to non-custody staff, who also had unrestricted access to cells.

4.27 Detention officers told us that they had received training to identify potential ligature points. Staff reported prompt action to rectify issues identified, usually within 24 hours. We found no ligature points.

4.28 There was no record of recent fire evacuation drills at either suite. Temporary handcuffs were available in both suites for such an event and staff knew the procedure for evacuation.

Recommendations

4.29 The cell floors at Bethnal Green should be deep cleaned and repainted and those at Limehouse should be resurfaced.

4.30 Regular health and safety checks should be carried out to a common standard.

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

4.32 Fire practice evacuations should be held regularly at both suites and documented.

Housekeeping points

4.33 The interview rooms at Bethnal Green should be refurbished.

4.34 All detainees should be told about the cell call bells and their use.

Personal comfort and hygiene

4.35 All cells contained a mattress and pillow. At Bethnal Green, mattresses, pillows and plinths were wiped down between uses but this did not take place at Limehouse, where no anti-bacterial spray was available. There were ample supplies of clean blankets at both suites.

4.36 Hygiene packs for women detainees were available on request but there was no information to indicate this, and some male DDOs indicated that they did not routinely inform female detainees of their availability. Other items, such as toothpaste, disposable razors and soap were available at both suites.

4.37 All cells had a toilet which was clean and serviceable. The toilet area was obscured on the CCTV system but detainees were not routinely informed of this at Bethnal Green. Toilet paper was provided only on request and one detainee told us that he felt embarrassed about having to ask for it. There were no hand-washing facilities in the cells. Basins in the corridors had a good supply of hot water, and at Limehouse there were mirrors, so that detainees could shave before going to court.

4.38 Showers were available, and those at Bethnal Green were clean, reasonably private and had hot water. At Limehouse, the shower afforded little privacy, particularly for female detainees. Only paper towels were available at both suites. In our custody record analysis, few detainees whose records were examined had been offered showers, including several who had gone to court without a shower.

4.39 Track suit tops and bottoms were provided for detainees whose clothing was seized for evidential purposes or unwearable. Paper suits were given to those who did not want cords removed from their clothing. Plimsolls were also available. There was no stock of underwear at either suite. We were told that detainees would not be released from either suite in paper suits.

Recommendation

4.40 Showers should be offered, especially to those detained overnight, and the shower at Limehouse moved to a more private location.

Housekeeping points

4.41 Mattresses and pillows should be wiped down with an anti-bacterial spray between uses.

4.42 Hygiene packs should be routinely offered to women detainees.

4.43 Detainees should be informed that the toilet area is obscured on the closed-circuit television.

4.44 Toilet paper should be available in all cells, subject to risk assessment.

4.45 Cotton towels should be provided.

4.46 Adequate stocks of underwear should be provided.

Catering

4.47 The police station canteens provided most meals during office hours. We were told that halal meals were available, although at Bethnal Green it appeared that anyone requiring these had to choose the vegetarian option. There were no meals identified as kosher. Outside office hours, microwave meals were provided at both suites, and these included halal dishes. While the custody record analysis showed that most detainees were offered meals at reasonable intervals, one person had been in custody for eight hours without a record of his being offered food. The temperature of meals was not taken before serving. Hot and cold drinks were provided regularly.

4.48 We were told that food handling training was included in the initial custody training. At Limehouse, all microwave meals were in date but they were stored in an unhygienic manner under a sink, as were cups.

Housekeeping points

4.49 Meals that are suitable for a range of dietary requirements should be provided.

4.50 Microwave meals, cups and other catering goods should be stored appropriately.

Activities

4.51 Both suites had a small, clean outside exercise yard but staff told us that exercise was rarely made available. Detainees were not routinely offered anything to read. At Bethnal Green, the only reading material available for detainees was eight novels (all in English) and an old newspaper. There were no books or magazines available at Limehouse. Family visits were not facilitated.

Recommendations

4.52 Provision should be made for detainees, particularly those held over 24 hours, to be offered exercise.

4.53 A suitable range of reading material should be provided, including for young people and those who cannot read English.

5. Individual rights

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

Rights relating to detention

5.1 We observed custody sergeants checking the circumstances of the detainee's arrest, to determine if detention was appropriate. However, most custody sergeants could recall only a few occasions when they had refused to detain. Use was made of voluntary attendance, although at Limehouse, some detainees attending voluntarily were detained in cells to await interview. Solicitors told us that they believed that detainees' rights were upheld by staff, that detainees were generally well treated and that officers progressed enquiries at a reasonable pace.

5.2 We observed detainees being told that they could inform someone of their arrest, and staff facilitated telephone calls promptly, but these were made in a public area, with little privacy (see recommendation 4.8). In our custody record analysis, 23% of the detainees whose records we examined wanted someone informed of their arrest. Of these, there was evidence in only three cases that custody staff had made attempts to contact the nominated person.

5.3 Detainees were asked if they had concerns about any dependants.

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

5.5 Data supplied by the CJD showed that in the current year, 111 immigration detainees had been held, predominantly at Bethnal Green; the average detention time had been just over 18 hours. Custody staff reported good relationships with the UK Border Agency, which they attributed to the proximity of two immigration officers based at Bethnal Green police station.

5.6 At both suites, staff provided all detainees with a leaflet summarising their legal rights and entitlements. These could be downloaded and printed for non-English speaking detainees in their own language but none had been adapted for those with learning difficulties or limited literacy. The use of interpretation services had improved since our last inspection. A professional telephone interpreting service, used with two-handset telephones, was readily available. We saw detainees of several nationalities having their rights explained to them through this facility, which appeared prompt and effective. Staff told us that there was a good face-to-face interpreting service available, to facilitate investigative interviews. Our custody record analysis confirmed that interpreters had been used for interviews when necessary.

5.7 Reviews of detainees in custody were mostly undertaken by a police inspector who had specific PACE responsibilities. Our observations and our analysis of custody records confirmed that most reviews took place face to face and on time. Where this was not possible, the reasons for the review being conducted over the telephone or delayed were recorded in the detention log.

5.8 The custody record system incorporated a pre-release risk assessment prompt to which custody sergeants had to respond before the record could be closed. The quality of these

assessments was variable. We observed the needs of vulnerable detainees being considered on release, and our custody record analysis showed that, in general, detainees' vulnerabilities had been addressed properly; for example, in the case of a juvenile who could not return to her home address, arrangements had been made for her AA to escort her to a relative's address instead. However, we also found two cases involving clearly vulnerable female detainees whose needs had not been addressed. One had involved a woman suspected of being a sex worker, who had been released in the early hours of the morning with no apparent consideration for her safety. On leaving the custody suites, detainees were given a comprehensive leaflet detailing a list of support agencies but this was available only in English.

Recommendations

5.9 Detainees who have attended the police station voluntarily should not be detained in cells while awaiting interview, unless there is a more substantive reason for them to be arrested.

5.10 All custody staff should complete comprehensive pre-release risk assessments, especially for vulnerable detainees.

Housekeeping points

5.11 The Metropolitan Police Service should further develop and promote alternative-to-custody approaches.

5.12 Staff should ensure that telephone calls are made, and recorded in the custody record, when detainees request that someone is informed of their detention.

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

Rights relating to PACE

5.14 During the booking-in process, detainees were told that they could read the PACE codes of practice, and adequate copies were available. Booking-in areas displayed posters in a range of languages reminding detainees of their right to legal advice, as well as information about the duty solicitor scheme. When detainees declined the services of a solicitor, we saw staff assuring them that they could change their mind later. This finding was supported by our custody record analysis, although reasons for declining legal advice were not always given by detainees, or recorded. Consultations with solicitors at the custody suites were mostly held in private but telephone consultations took place in public areas. Defence solicitors described good relationships with custody staff, and the interactions we saw were professional. Some delays were experienced by defence solicitors in gaining access to the custody suite at Bethnal Green. At both suites, solicitors were routinely offered a copy of their client's custody record.

5.15 The availability of AA services had improved slightly since the previous inspection but was still problematic. Custody staff preferred to involve members of the detainee's family when an AA was required. When this was not possible or appropriate, AAs for juvenile detainees could be obtained during office hours through the local Youth Offending Service, and out of office hours through a request to social services; for vulnerable adults, staff had to request AAs from social services at all times. This involved long delays. We observed one request for an AA for a

vulnerable adult being declined by social services because the individual did not have any mental health issues, and in another case because the detainee did not live in the borough, both resulting in alternative arrangements having to be instigated. In the latter case, the detainee had had to be bailed to return at a later date; we were told that this was a common occurrence in such circumstances and led to vulnerable people spending unnecessarily long periods in detention. At both suites, there was uncertainty among some custody staff about whom to contact to obtain AA services.

5.16 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] We were told that the local authority could rarely supply PACE beds to accommodate juveniles who were charged before their attendance at court, which meant that those that could not be bailed were kept in police custody overnight.

5.17 Custody staff told us that detainees were not interviewed while under the influence of drugs and alcohol. This accorded with the findings of our check of those in custody at the time of the inspection.

5.18 Detainees were transported to court in a timely manner but the court cut-off times were too early, at around 1pm, although some flexibility was shown for individual cases. The Saturday cut-off time at Limehouse was reported to be as late as 12pm, while at Bethnal Green it could be 9am, which in some cases resulted in unnecessarily long stays in custody. The court cut-off times were not clear, as they seemed to vary from day to day.

5.19 The management arrangements for DNA had improved. There was an effective process for the prompt collection of DNA samples. However, other forensic samples were being stored together with DNA samples. This could lead to confusion, resulting in the loss or misplacing of samples.

Recommendations

5.20 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.

5.21 The MPS should engage with the local authorities in London to ensure the provision of local authority accommodation for juveniles who have had bail denied.

5.22 Senior police officers in the borough operational command unit should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody.

Housekeeping point

5.23 DNA samples should not be stored with other forensic samples.

[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.

Rights relating to treatment

5.24 Detainees were still not routinely told how to make a complaint as part of the custody process, in line with the Independent Police Complaints Commission (IPCC) 2010 statutory guidance.[6] If a detainee wished to make a complaint, staff contacted the PACE/duty inspector and it was his or her decision as to how the complaint would be progressed, and whether to note it while the detainee was still in custody or deal with it once they had been released. We saw a complaint being taken from a detainee at Limehouse while still in custody. Some analysis of complaints was being undertaken.

5.25 The borough received information on complaints and the BOCU deputy commander utilised a local resource to analyse complaints and hold managers to account at a monthly performance board attended by the custody manager. There had been four custody-specific complaints in the previous six months. A trend identified from these complaints had been a lack of accuracy in recording information on custody records and we were told that this had been disseminated to custody staff. Generally the management of complaints had improved since our last inspection.

Recommendation

5.26 Detainees should be routinely informed about how they can make a complaint about their care and treatment, in line with the Independent Police Complaints Commission 2010 statutory guidance, and be able to do this before they leave custody.

Good practice

5.27 *The local analysis of complaints held managers to account and provided the opportunity for learning and feedback to staff.*

[6] IPCC statutory guidance (2010)

6. Health care

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

Clinical governance

6.1 The BOCU employed registered nurses and FMEs to provide health services. Mental health services were provided by two community mental health teams, employed by East London NHS Foundation Trust. Substance use services were provided by the local drug intervention programme (DIP) team.

6.2 Overall, primary health care services had improved. There were reasonably good clinical governance arrangements, which included clear lines of management and an escalation process, so that staff could obtain further advice if required. Nurses had been recruited since the previous inspection and their experience included community nursing and accident and emergency services. FMEs were self-employed and were contracted to the police. There was a newly appointed medical director and custody nurse area manager.

6.3 There was a comprehensive induction programme for new nurses. They received a five-week induction, which covered the mandatory training for working in the custody suite environment, including infection control, basic life support and mental health awareness. There were no opportunities for staff to have clinical supervision but there was a programme for staff appraisal. Staff had access to regularly planned continuing professional development.

6.4 The custody nurse area manager investigated any complaints or contract breaches that had been raised but there was no formal means to report or monitor breaches to their contract obligations (see housekeeping point 6.18).

6.5 The nursing staff that we observed were courteous, caring and respectful. Staff had access to interpreting services if required but there was no telephone in the medical room at Limehouse.

6.6 The state of the clinical rooms was adequate in both sites. The medical room in the Bethnal Green suite was of a reasonable size and contained modern equipment, and in the Limehouse suite was small but tidy. Infection control audits had not been undertaken on either site. We saw both rooms having their floor mopped each day but the process was not sufficiently thorough, and there were no cleaning schedules. Clinical and forensic equipment was in date. Sharps bins were not secured to the wall but they had been signed and dated on start of use. Some sharps bins contained domestic rubbish. We did not observe patient information leaflets or health promotion information.

6.7 Medicines were stored appropriately in the medical room of the custody suites. There was minimal stock in each cupboard, which was recorded in a book and signed out when used. We found the records to be accurate and there was an audit process to check the records. We were told that custody staff never administered medication and that a nurse was contacted if a detainee required medications. Nurses were able to supply and administer a reasonable range of medications using patient group directions.

6.8 Emergency equipment was available and included an automated external defibrillator, oxygen and suction, which were checked regularly. First-aid kits were sealed and staff were able to tell us how to replenish the kit when used. All staff we spoke to were up to date with their life support training.

Recommendation

6.9 There should be regularly reported infection control audits and robust infection control procedures for all the clinical rooms, which should be clean and be capable of being used for the taking of forensic samples.

Housekeeping points

6.10 A three-way telephone should be available in the medical room at Limehouse suite, so that confidential calls and access to interpreting services are possible.

6.11 Patient information leaflets and health promotion leaflets should be available.

Patient care

6.12 One nurse was on duty to cover each 12-hour shift. No time was formally allocated for a handover, so it was achieved by nurses either coming in early or staying late. The nurse on duty was based at Bethnal Green and covered both sites. Nurses led the clinical care, with one FME contactable by telephone for advice or to request attendance if needed. The need for this had been less frequent since the nursing services had started. During the inspection, a doctor was called but could not attend to see a detainee, as he or she was at a conference.

6.13 No monthly statistics were collated to demonstrate that the nursing or medical services were adhering to their Service Level Agreement, although at Bethnal Green detainees could be seen immediately. We were told that sometimes nurses were delayed in attending the Limehouse site if they were busy at Bethnal Green.

6.14 We witnessed good nursing care and there were good working relationships between nurses and custody staff. Information sharing was generally appropriate.

6.15 Female detainees could not be guaranteed to see a female doctor if needed, although a chaperone would be made available.

6.16 Health professionals used paper records to record their contemporaneous notes about a consultation; the nurses used a custody health assessment plan, as did some, but not all, of the FMEs. Clinical information and medicines administered were also documented electronically on NSPIS; again, not all FMEs contributed sufficient information to the electronic system. Nurses' records were put in a locked cupboard and were later transferred to locked filing cabinets in the manager's office at Bethnal Green. Records were stored in line with Caldicott guidelines.[7] As the clinical manager and medical director were new, a comprehensive audit of clinical records had not yet started but there were plans to roll out the audit process used in the other BOCU sites. The nurses' records we looked at showed that, in most cases,

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

the standard of record keeping was generally compliant with professional record-keeping guidance.

Recommendation

6.17 There should be robust monitoring arrangements for primary care medical and nursing services and the medical rota should be reviewed to ensure there is always a doctor who can attend the custody suite when requested.

Housekeeping point

6.18 All clinical staff should record relevant clinical information on the electronic system, to ensure continuity of care for detainees. There should be regular record-keeping audits.

Substance use

6.19 A drugs worker from Tower Hamlets DIP was based at Bethnal Green every day between 7am and 10pm. Detainees were assessed and referred to community drug or alcohol teams where appropriate. There were good links with drug services provided by NHS Tower Hamlets, including primary care alcohol and drug services offered by local GP practices; Isis Women's Service, a drug service for women offering a range of treatments (including one-to-one support), mental health screening and blood-borne virus checks; Lifeline Project, a national voluntary agency offering structured programmes and counselling; Nafas, a culturally sensitive drug education and prevention initiative for young people and black and minority ethnic groups run by the Bangladeshi Drug Project.

6.20 The DIP team consisted of arrest referral workers, court workers, throughcare workers and outreach workers who provided assessment, advice and structured group work for adults. When needed, there were effective links with blood-borne virus services, including those provided by the Isis Women's Service. There were also links with the community psychiatric nurse. Substitute prescribing was available.

6.21 The DIP worker at Bethnal Green routinely carried out 'cell sweeps', to identify detainees with drug or alcohol problems, and telephoned Limehouse daily – and attended if required. There were good working relationships between this team, custody staff and community prescribers.

6.22 All detainees who had committed a 'trigger offence' were automatically drug tested; refusal of a test constituted a further offence. Arrest referral workers saw detainees during duty hours. When they were unavailable or off duty, custody staff made appointments for detainees with these workers. Failure to attend resulted in breach proceedings being taken. There were suitable tracking methods that ensured that detainees had the opportunity to attend appointments.

6.23 There were limited alcohol services across Tower Hamlets, and generally the DIP team integrated alcohol support into their work with drug users.

6.24 There was good access to needle exchange services in the community, although clean needles and syringes were not available in the custody suites. Drug workers signposted juveniles to relevant services.

Mental health

6.25 East London NHS Foundation Trust provided mental health services. The Isle of Dogs community mental health team provided services to the Limehouse suite, and the Bethnal Green community mental health team covered the Bethnal Green suite. There were mixed views about the quality of mental health services. Custody staff in both suites told us that: 'when they come they are good'. However, mental health services were criticised for not always being responsive, and, in particular, there were difficulties if a detainee was from a different borough or required an assessment out of hours. We observed a detainee with mental health problems being held for 13 hours before being bailed and taken directly to the accident and emergency (A&E) department by the police. The delay in this detainee's mental health assessment occurred because neither the community mental health team nor the FME attended the suite. There was an expectation that an FME needed to refer to the mental health teams; this policy was new and had not been communicated to the relevant staff. There were no mental health nurses in the primary care team and there had been little mental health awareness training for nursing or custody staff (see main recommendation 2.24).

6.26 The Tower Hamlets Link Worker Service, a voluntary organisation, offered an outreach service for people with mental health problems (including substance misuse) who come into contact with the police and criminal justice system. The workers provide advice, information, advocacy and support for people whose needs were not easily met by mainstream mental health services. Support included counselling, assistance with housing, benefits and diversion into statutory mental health services.

6.27 There were no policies and procedures in the suites and no monitoring data were available. Joint working appeared poor at an operational level and we saw no evidence of an audit of mental health services. We were told that there were good strategic meetings in place, such as the Mental Health Act implementation group, and that there were good links with the police liaison officer, although not all nursing and custody staff were aware of the post holder and how to contact him. Strategic plans were not communicated and appeared not to have impacted on clinical practice. Mental health services remained limited and two of our recommendations in the previous report had not been addressed, and are repeated here.

6.28 The custody suite had not been used as a place of safety for section 136 assessments during the financial year; all 78 section 136 assessments in this period had been undertaken at the place of safety for the borough – the A&E department at The Royal London Hospital in Whitechapel. There was a draft protocol for the use of the place of safety, which had been written by the acute NHS trust, with no evidence of multi-professional involvement. Staff at the A&E department did not know who currently held the post of police liaison mental health officer.

Recommendations

6.29 There should be mental health awareness training for nursing and custody staff.

6.30 There should be multi-agency policies and procedures that staff should work towards, to ensure consistent support for detainees.

6.31 There should be robust multi-agency policies, procedures and audit arrangements to ensure that a consistent quality of mental health services and support is delivered to detainees.

7. Summary of recommendations

Main recommendations

7.1 Arrangements for the quality assurance of custody records and associated issues through dip-sampling should be introduced and recorded, with a clear audit trail. (2.22)

7.2 There should be a clearer focus on ensuring that the needs of all detainees are addressed, including juveniles, women, those with disabilities and members of ethnic minorities. (2.23)

7.3 There should be a liaison/diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services. (2.24)

Recommendations

Treatment and conditions

7.4 Arrangements in booking-in areas should allow for private communication between detainees, staff and legal representatives. (4.8)

7.5 Defective or unsuitable CCTV monitors at Limehouse should be replaced. (4.15)

7.6 The use of strip searching should be monitored and any potential over-use investigated and corrected. (4.16)

7.7 Shift handovers should take place jointly between the outgoing and incoming shifts and include designated detention officers. (4.17)

7.8 Handcuffs should only be used when necessary, justifiable and proportionate, and they should be removed as soon as possible after arrival at the custody suite. (4.21)

7.9 The Metropolitan Police Service should collate data about the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.22)

7.10 The cell floors at Bethnal Green should be deep cleaned and repainted and those at Limehouse should be resurfaced. (4.29)

7.11 Regular health and safety checks should be carried out to a common standard. (4.30)

7.12 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.31)

7.13 Fire practice evacuations should be held regularly at both suites and documented. (4.32)

7.14 Showers should be offered, especially to those detained overnight, and the shower at Limehouse moved to a more private location. (4.40)

7.15 Meals that are suitable for a range of dietary requirements should be provided. (4.49)

7.16 Microwave meals, cups and other catering goods should be stored appropriately. (4.50)

7.17 Provision should be made for detainees, particularly those held over 24 hours, to be offered exercise. (4.52)

7.18 A suitable range of reading material should be provided, including for young people and those who cannot read English. (4.53)

Individual rights

7.19 Detainees who have attended the police station voluntarily should not be detained in cells while awaiting interview, unless there is a more substantive reason for them to be arrested. (5.9)

7.20 All custody staff should complete comprehensive pre-release risk assessments, especially for vulnerable detainees. (5.10)

7.21 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.20)

7.22 The MPS should engage with the local authorities in London to ensure the provision of local authority accommodation for juveniles who have had bail denied. (5.21)

7.23 Senior police officers in the borough operational command unit should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.22)

7.24 Detainees should be routinely informed about how they can make a complaint about their care and treatment, in line with the Independent Police Complaints Commission 2010 statutory guidance, and be able to do this before they leave custody. (5.26)

Health care

7.25 There should be regularly reported infection control audits and robust infection control procedures for all the clinical rooms, which should be clean and be capable of being used for the taking of forensic samples. (6.9)

7.26 There should be robust monitoring arrangements for primary care medical and nursing services and the medical rota should be reviewed to ensure there is always a doctor who can attend the custody suite when requested. (6.17)

7.27 There should be mental health awareness training for nursing and custody staff. (6.29)

7.28 There should be multi-agency policies and procedures that staff should work towards, to ensure consistent support for detainees. (6.30)

7.29 There should be robust multi-agency policies, procedures and audit arrangements to ensure that a consistent quality of mental health services and support is delivered to detainees. (6.31)

Housekeeping points

Strategy

7.30 A custody web page on the force intranet with links to relevant newsletters and other custody information should be developed. (3.10)

Treatment and conditions

7.31 Items used for religious observance should be appropriately stored and a reliable means of indicating the direction of Mecca should be provided. (4.9)

7.32 Custody sergeants should carry out regular quality checks of person escort records, ensuring that they are legible and are retained with the custody record. (4.18)

7.33 The interview rooms at Bethnal Green should be refurbished. (4.33)

7.34 All detainees should be told about the cell call bells and their use. (4.34)

7.35 Mattresses and pillows should be wiped down with an anti-bacterial spray between uses. (4.41)

7.36 Hygiene packs should be routinely offered to women detainees. (4.42)

7.37 Detainees should be informed that the toilet area is obscured on the closed-circuit television. (4.43)

7.38 Toilet paper should be available in all cells, subject to risk assessment. (4.44)

7.39 Cotton towels should be provided. (4.45)

7.40 Adequate stocks of underwear should be provided. (4.46)

Individual rights

7.41 The Metropolitan Police Service should further develop and promote alternative-to-custody approaches. (5.11)

7.42 Staff should ensure that telephone calls are made, and recorded in the custody record, when detainees request that someone is informed of their detention. (5.12)

7.43 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.13)

7.44 DNA samples should not be stored with other forensic samples. (5.23)

Health care

7.45 A three-way telephone should be available in the medical room at Limehouse suite, so that confidential calls and access to interpreting services are possible. (6.10)

7.46 Patient information leaflets and health promotion leaflets should be available. (6.11)

7.47 All clinical staff should record relevant clinical information on the electronic system, to ensure continuity of care for detainees. There should be regular record-keeping audits. (6.18)

Good practice

7.48 The local analysis of complaints held managers to account and provided the opportunity for learning and feedback to staff. (5.27)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Fiona Shearlaw	HMIP inspector
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Peter Dunn	HMIP inspector
Helen Carter	HMIP health care inspector
Mark Ewan	HMIC inspector
Paul Davies	HMIC inspector
Roger James	CQC inspector
Michael Skidmore	HMIP researcher