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

4–9 February 2013

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the Glossary of terms on our website at: http://www.justice.gov.uk/downloads/about/hmipris/Glossary-for-web-rps_.pdf

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

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1. Introduction

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

Westminster police had implemented a centralised custody management structure which worked well. Line management was clear and staffing levels were found to be appropriate. However, the force needed to consider the ratio of men to women in their detention officer workforce, and to have a sufficient number of female staff available to provide appropriate care for female detainees.

Detainees were treated with care and the officers had a respectful approach. All staff were observed to respond appropriately and gain cooperation from vulnerable detainees. There was good health care provision, including a team of registered mental health nurses, who visited suites daily. Handover arrangements were of a good standard and included the whole team, including health care staff, even though shift patterns did not allow time for these to take place. Staff had to arrive early for their shift for a handover to take place.

Notwithstanding the care shown by staff, the lack of private booking-in facilities was a particular problem and staff were sometimes heard discussing sensitive details of a detainee's arrest in the presence of other people in the suite.

The operation of the virtual courts system at Charing Cross gave cause for concern. Delays in the provision of court warrants meant that people were not immediately transferred to prison, prolonging their stay in custody.

When we inspected Westminster, the force adhered to the Police and Criminal Evidence Act definition of a child, treating 17-year-olds as adults, whereas in all other UK law and treaty obligations 17-year-olds are treated as children. We therefore made our standard recommendation calling for appropriate adults to be available to support 17-year-olds as well as other children and young people. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law and the government announced that it would accept this judgment. We welcome this move, but will continue to include this recommendation until there is a change in the law.

We observed a 'bedding down' culture, meaning that people arrested in the evening would not have their investigations progressed until the following morning. We also found that officers had little awareness of PACE code G, which states that arrest is required only when voluntary attendance is not appropriate. The accumulated effect of these deficits created an extra burden and risk for custody staff and detainees.

In summary, the force has some good systems in its management of custody, and professional staff, supported by health care personnel. However, there are some actions that the force can take to reduce the number of people in custody.

This report provides a number of recommendations to assist the force and the Police and Crime Commissioner to improve provision further. We expect our findings to be considered in

the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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June 2013

2. Background and key findings

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

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 There were five designated custody suites in the Borough of Westminster. Charing Cross and Belgravia were the only two being used full time during the inspection. Harrow Road and Paddington were used in specific operations or as an overflow. The West End suite was being used by another police area. According to Metropolitan Police Service (MPS) data, in the year before the inspection there had been 17,016 arrests in the Westminster borough operational command unit (BOCU). A total of 426 detainees had been arrested for immigration matters.

Custody suite	Usage	Number of cells
Charing Cross	Full time	42
Belgravia	Full time	16
West End Central	Used by another borough	
Harrow Road	Specific operations and overflow	
Paddington Green	Specific operations and overflow	

2.4 The HMIP/HMIC methodology normally includes a survey of prisoners recently held in the suites being inspected, but because the sample was too small to yield statistically significant data, the results of the survey were not used.

Strategy

2.5 The strategic leadership of custody was the responsibility of the borough commander. There was a centralised custody management structure, which worked well. Staffing levels were

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

adequate. Line management systems ensured consistency, and the use of cover staff was rare.

2.6 Designated detention officers (DDOs) were trained to book in detainees, and we observed this to work well, although not all shifts operated this practice.

2.7 Quality assurance monitoring of custody records was regular, recorded and auditable. All DDOs and custody sergeants performing custody duties had received training but the provision of custody refresher training was variable.

2.8 Senior management visits to custody suites were infrequent. No internal custody newsletter was produced for staff. There was a shared computer drive but it was not easy to use.

2.9 Partnership arrangements at a strategic level were unclear. A new Joint Prosecution Service (JPS) model structure might address this to some extent, but it was unclear how this was being progressed or managed.

Treatment and conditions

2.10 Staff dealt well with detainees, and had a positive and respectful approach. Most custody sergeants made efforts to gain cooperation from uncooperative or vulnerable people and generally there was a good awareness of individuals in custody.

2.11 There was an imbalance in the ratio of male staff to female detainees. Sometimes male staff dealt with personal care issues for women. All detainees were asked whether they had any dependency issues

2.12 Suites had detention rooms for young people and these were used flexibly. Access for those with disabilities was provided on the ground floor in Charing Cross, but there were no adaptations in Belgravia. Holy books were available in both custody suites but they were not respectfully stored.

2.13 There was a lack of privacy in the booking-in areas. Staff lacked sensitivity in their management of personal and private information about detainees. They were observed openly discussing information that should have been kept confidential, and private conversations could be easily overheard by others waiting in the custody area.

2.14 Risk assessments were carried out, and while we saw these being undertaken diligently, there were some gaps in the information recorded. People were placed on observations, with little explanation as to why.

2.15 All staff carried anti-ligature knives and additional sets were available in the custody suite. Emergency evacuation boxes were available but not all members of staff knew where to find them. Cell call bells were working and responded to promptly.

2.16 Shift handovers were of a good standard and involved the whole team, and in one we observed, nursing staff were included. Pre-release risk assessments were completed in most cases. Gaps were identified in cases where detainees were bailed by the 'virtual court' or where there was an early morning or late night release. There was no information on how detainees released late at night would get home. Most people leaving custody were given leaflets and offered referrals to outside agencies.

2.17 Staff did not record use of force appropriately, which meant that there was no strategic collection of information about use of force to inform staff training. Most strip-searches, with some notable exceptions, were appropriately authorised.

2.18 Mattresses and pillows were available in all cells. Some cells contained graffiti. Shower facilities were available but underused and in some cases not private. There was no exercise yard in either custody suite. Reading materials were available but there was nothing specific for young people or in languages other than English.

Individual rights

2.19 Sergeants were prepared to query and refuse detention in some cases, although they complained of pressure from managers if they refused detention. The use of virtual courts caused prolonged stays in police custody for those refused bail. The delay in receiving court warrants meant that many detainees were not immediately transferred to prison and they were therefore unable to access their entitlements as remand prisoners.

2.20 Custody staff assured us that no children had been brought to the custody suite as a place of safety; however, due to the unavailability of appropriate adults (AAs) at night, and delays in a relative responding to the request, the custody suite had been used as a place of safety on at least one occasion. AA services were available until about 10pm. Custody sergeants were satisfied with the service when it was available.

2.21 Both custody suites received detainees facing immigration removal. During working hours, the service provided by the UK Border Agency (UKBA) was of a good standard but the out-of-hours service was poor.

2.22 Professional telephone interpreting services were available for detainees whose first language was not English. Video conferencing was also available. Rights and entitlements leaflets were available in different languages for those who required them, but were badly printed at Charing Cross.

2.23 The Police and Criminal Evidence Act 1984 (PACE) codes of practice were available in custody suites. Solicitors were offered custody records. PACE reviews were undertaken by the inspector but were not always recorded appropriately, especially when they had taken place by telephone; on such occasions, the detainee often did not speak directly to the inspector. Some reviews were undertaken while detainees were asleep, and it was not clear whether they were told about the review on waking.

2.24 Court cut-off times were reasonable, except in Camberwell, where the 1pm cut-off time was too early.

2.25 There were inconsistencies among custody staff in the management of complaints. Custody staff said that they would advise detainees to make complaints post-release, unless the complaint involved their stay in custody. Managers told us that they expected all complaints to be taken by custody staff.

Health care

2.26 The overall governance of health care was effective and health care professionals had good access to a range of health-specific policies and clinical guidance, including an appropriate range of patient group directions for nurses to administer medicines.

2.27 Health care rooms were clean and dedicated to use by health care staff. There was an effective safekeeping system for keys, including medication cupboards. There was appropriate use of eCHAPS clinical records, which could be seen only by health care professionals and were selectively reproduced on the national strategy for police information systems (NSPIS), protecting the detainee's confidential medical information. There were some gaps in recording practices.

2.28 Staff treated detainees respectfully, with appropriate care by custody and nursing staff, who were also actively involved in handovers.

2.29 Substance use workers attended both suites daily, between 7am and 10pm. They responded to referrals for drug testing and made contact with detainees with potential drug problems. There were links with the community drug agencies and syringe exchange services.

2.30 There was a good response to detainees' mental health needs by a team of registered mental health nurses. They visited suites daily and were on call during the weekend.

Main recommendations

2.31 Booking-in desks should allow effective and private communication between custody staff, detainees and their legal representatives.

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

2.33 The Metropolitan Police Service should develop and promote alternative to custody approaches, and custody sergeants should ensure that the 'necessity test' for arrest is properly applied.

2.34 The MPS should work with HM Courts and Tribunals Service to ensure that the virtual court system does not result in unnecessarily long stays in police custody.

National issues

2.35 Appropriate adults should be available out of hours, given informed consent where necessary, to support children and young people aged 17 and under and vulnerable adults in custody.

3. Strategy

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

Strategic management

3.1 The MPS had a Territorial Policing Criminal Justice (TPCJ) Directorate, led by a commander within territorial policing headquarters. A superintendent was responsible for the day-to-day management of the TPCJ.

3.2 Responsibility for the day-to-day management of Westminster's custody suites and delivery of custody services had been devolved to the BOCU. Accountability therefore rested with the BOCU commander, who was a chief superintendent.

3.3 The TPCJ had an inspection function for audit and compliance, health and safety and the implementation of *Safer Detention and Handling of Persons in Police Custody 2012* (SDHP) guidance.

3.4 Policies were signed off at a strategic command level within the MPS, and the TPCJ provided standard operating procedures (SOPs) which supported the delivery of force policies by each custody suite across the Metropolitan Police area. The SOPs covered a broad spectrum of matters, including use of police custody, use of closed-circuit television (CCTV) and guidance to custody staff on the supervision of detainees.

3.5 Strategic leadership of the custody function for the Borough of Westminster was provided by the borough commander. At the senior leadership team (SLT) level, a detective superintendent led the custody function. He line-managed a detective chief inspector with responsibility for criminal investigation and custody, who in turn managed a custody manager who was an inspector, and four borough custody inspectors. Staff told us that the SLT would regularly visit the custody suite.

3.6 There were two designated full-time custody suites, located at Charing Cross (42 cells) and Belgravia (16 cells). There were also three stand-by suites at West End Central, Paddington Green and Harrow Road. The borough was responsible for the maintenance of these stand-by suites. At the time of the inspection, part of the West End Central suite was being used by the Borough of Lambeth, and the Paddington Green and Harrow Road suites were closed. Although we undertook no observations at the stand-by suites, we examined the physical conditions as part of the inspection.

3.7 The TPCJ had facilitated a self-assessed risk register for all MPS custody suites. The BOCU commander had ownership of the risks and had introduced measures to mitigate them.

3.8 Staffing levels in the custody suites were adequate and comprised four teams of permanent custody sergeants, each line-managed by a borough custody inspector. The custody sergeants were supported by, and line-managed, permanent DDOs, who were responsible for the ongoing care and welfare of detainees. The DDOs had received training to book in detainees under the supervision of custody sergeants, and we observed this to work well, although not all shifts operated this practice during the inspection. We were told that the staffing arrangement was virtually self-sufficient, rarely requiring cover from operational

resources, and this was reflected in our observations. In addition to the four borough custody inspectors, there was a custody manager (inspector) for the borough and two custody support sergeants. These arrangements provided a clear line-management structure and consistent working practices.

3.9 There were plans to align custody resources with the Local Policing Model programme from April 2013. We were told that this would involve changes to line management and shift patterns between borough custody inspectors, custody sergeants, DDOs and custody nurses.

3.10 An SLT member chaired three times daily 'pace setter' meetings. The detective chief inspector, custody manager or borough custody inspector attended these meetings, raising custody issues as necessary. Unresolved or exceptional custody issues could be discussed at the weekly SLT meeting and there was informal weekly liaison between the detective superintendent and the detective chief inspector. There was daily liaison between the detective chief inspector, custody manager and borough custody inspectors. Custody health and safety issues were discussed at the quarterly BOCU health and safety meeting. There was a monthly custody management meeting, chaired by the detective chief inspector, which included custody sergeant, DDO and custody nurse representation.

3.11 There were good quality assurance measures, and there was evidence of dip-sampling of custody records, which incorporated person escort records (PERs) and some dip-sampling of CCTV.

3.12 There were processes for dealing with adverse incidents. A form was generated from the computer system in custody and passed on to the custody manager, borough custody inspector and the TPCJ. Although the BOCU had a central repository for recording adverse incidents and other custody-related communication, the structure on the intranet was not easy to use. More urgent matters were communicated directly to staff by email. Independent Police Complaints Commission (IPCC) 'learning the lessons' information was available on the force intranet, and staff were expected to update themselves regularly. However, staff we spoke to were unaware of these bulletins. The BOCU did not generate a newsletter and staff told us that they had not seen the TPCJ custody newsletter for several months.

Housekeeping point

3.13 The borough should review the custody-specific link on the borough operational command unit intranet pages.

Partnerships

3.14 Partnership arrangements were described as good. However, the Local Criminal Justice Board (LCJB) meetings had lapsed. The BOCU was involved in establishing arrangements with criminal justice partners for the implementation of the JPS model, which was the replacement for the LCJB, but it was unclear how this was being progressed or managed.

3.15 There was an established independent custody visitor (ICV) scheme, and weekly visits were undertaken at both suites. ICVs told us that there were sometimes delays in admittance to custody during shift handovers. Police officers regularly attended ICV panel meetings. ICVs said that immediate issues were dealt with effectively and that they received feedback on outstanding issues.

Recommendation

3.16 The borough should work with criminal justice partner agencies to ensure that regular senior management meetings with criminal justice partners are sustained.

Housekeeping point

3.17 The borough should work with the independent custody visitor scheme volunteers to eradicate delays in their admission to custody suites.

Learning and development

3.18 All DDOs and custody sergeants performing custody duties had received training before working in custody. Yearly mandatory training was provided, but the provision of custody refresher training was variable, with some staff saying that they had not received such training.

Housekeeping point

3.19 There should be management oversight of refresher training, to ensure that all staff working in custody receive it at least annually.

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 Staff engaged with detainees professionally and respectfully. We observed custody sergeants dealing with vulnerable detainees sensitively. DDOs responded to detainees' needs and worked collaboratively with custody sergeants. We saw a homeless detainee brought into the custody suite in a very agitated state. He had many self-harm warning markers from his previous times in custody but refused to engage in booking in. The custody sergeant was very patient, encouraging the detainee to answer the risk assessment questions, and involved other custody staff to establish a rapport with the detainee and devise an appropriate care plan.

4.2 At Charing Cross, there were four booking-in terminals on each of the two floors. These had no privacy screens and there was no separate room for private booking in. In addition to the lack of space, staff lacked sensitivity and awareness when discussing personal and private information about detainees; conversations could be overheard by other people waiting in the custody area. The lack of privacy was exacerbated by the absence of a holding area for detainees and officers, who had to sit on a bench in the booking-in area until they could be dealt with. At Belgravia, there was a separate private booking-in desk, but we were told that it was rarely used. We observed a custody sergeant there giving sensitive information about a detainee over the telephone to a member of the public who claimed to be a relative. Non-custodial staff were often present and conversations about detainees' alleged offences were held in the hearing of others (see main recommendation 2.31).

4.3 Although some custody staff were aware of diversity issues, we had concerns about provision for female detainees. Sometimes all the custody staff were male, and they dealt with the personal care of women. At Charing Cross, a male DDO attended a female detainee who had removed her clothing in her cell. Although she was in a state of undress, custody staff did not request that a female officer attend the suite until we suggested it. The detainee required sanitary products, which the male DDO dealt with. A female officer arrived at the custody suite an hour later. There were also delays in one female detainee being seen by a health care professional (HCP) during the night as there was no female DDO on shift to chaperone her consultation with the male nurse. At Belgravia, we saw a woman having to wait 20 minutes before a female member of staff arrived to search her.

4.4 Our analysis of 30 custody records included five (17%) women. There were designated questions in the risk assessment asking women if they were pregnant and if they wanted to see a female member of staff. There was no record of women being told of the availability of feminine hygiene products. The review of a detainee who was 34 weeks pregnant noted her pregnancy and that she should be released at the earliest opportunity. When she had rung the cell call bell and said she felt breathless, the attending DDO had been dismissive, and there was no record of this detainee seeing an HCP.

4.5 There were designated detention rooms for children, located close to the custody desk, and good use was made of them. We saw staff speaking appropriately to two children in custody who had been referred to the local youth offending team (YOT) for a final warning, and checked that they understood this. Custody sergeants told us that if the custody area was quiet

and there were no risk concerns, children could wait with their AA on the bench if their interview was imminent. They had a good awareness of safeguarding issues affecting young people or vulnerable adults, and details of agencies for referral if they identified any concerns. All detainees were asked whether they had any dependency issues.

4.6 Detainees were asked during booking in if they had any religious or dietary needs. Prayer mats, a compass, a Qur'an, several Bibles and religious books were available at both custody suites.

4.7 There were two adapted cells on the ground floor at Charing Cross for older detainees or those with disabilities. The cell call bells were lowered so that a detainee could press the button from a seated position. There was also an adapted shower and toilet nearby. There was step-free access to the ground floor of the custody suite and a ramp leading to the first floor. There were no adaptations at Belgravia. A portable hearing loop was available at Charing Cross, but not at Belgravia, but staff were unsure of how to use it. Staff at Belgravia told us that they had provided older detainees with extra mattresses to enhance their comfort.

4.8 Custody sergeants and DDOs at Charing Cross were aware of the needs of transgender detainees when they were searched, but some staff at Belgravia did not know how to search transgender people.

Recommendation

4.9 There should be sufficient female staff available to attend to the needs of female detainees.

Housekeeping points

4.10 Confidential conversations about detainees should take place only where they cannot be overheard by non-custody staff and visitors.

4.11 Staff should familiarise themselves with the use of equipment such as hearing loops.

4.12 Staff should be briefed about the correct way of searching transgender detainees, in accordance with Annex L of the PACE codes of practice C.

Safety

4.13 At Belgravia, when the suite was busy, the booking-in areas became congested with non-custody staff and this contributed to a chaotic atmosphere. Custody staff did not have adequate control over the suite in several cases and were often unaware of who was present within the suite. The booking-in area at Charing Cross was managed better, with custody sergeants checking the identities of other staff present.

4.14 Custody sergeants generally carried out the initial risk assessment, explaining its purpose to detainees. Custody sergeants asked probing questions if detainees divulged that they had harmed themselves or if there were health concerns. Our custody record analysis showed that risk assessments contained important information such as accounts of detainees' medication and history of self-harm, as well as their comments about their current state of mind. However, in many instances, the risk assessment did not appear to provide a clear rationale for the level of observations put in place, whereas in other cases, levels of observations seemed

inadequate. For example, an intoxicated detainee had not been put on rousing observations, and a detainee had been put on standard 60-minute observations even though it had been his first time in custody.

4.15 Children and young people were mostly subject to 30-minute observations. For all of the detainees we observed being booked in, the Police National Computer was checked and warning markers noted.

4.16 Custody sergeants and DDOs worked well together in conducting, conferring about and reviewing observations, such as ending rousing checks when detainees became sober. Custody sergeants managed risk proportionately; they did not routinely remove detainees' shoes or clothes with cords attached.

4.17 At both suites, we observed that DDOs and police officers given responsibility for close proximity supervision of vulnerable detainees were well briefed by the custody sergeant, gave detainees their full attention and engaged with them. Staff were generally diligent in conducting rousing checks for detainees who were intoxicated, noting them in the custody record, and magnetic '4 Rs' signs were placed on the relevant cell doors as a reminder. DDOs showed good care and concern for vulnerable detainees. Our custody record analysis found that observations were mostly timely, although there were a few instances where observations had lapsed by up to 10 minutes. The custody records of a Paddington Green detainee who had been subject to 30-minute observations showed that these had lapsed significantly, with one gap of an hour and another gap of 47 minutes between observations.

4.18 At Charing Cross, 16 cells were monitored by CCTV, with monitors behind the custody desk on both floors. On the first floor there were two larger monitors above the custody desk which staff could use to focus on detainees about whom they had particular concerns. All staff carried anti-ligature knives, all marked as single-use blades, with spares behind the custody desk. Notices at the entrance to each cell corridor reminded anyone entering the corridor that they should have a ligature cutter and cell key.

4.19 Custody staff handovers were excellent. Although shift patterns allowed no time for these, staff arrived early for their shift to enable a handover to take place. Those we observed at both suites were of equal standard and took place in two stages: firstly between custody sergeants and individual DDOs, and then as a collective briefing of the DDOs by one of the custody sergeants. Some of the custody sergeants had different shift starting times, which might have led to handover information becoming confused or diluted. In one such instance we observed, the sergeant with the later starting time had to self-brief because the other sergeant was busy booking in detainees. At Charing Cross, the evening handover we observed included health care staff. The booking-in area was cleared for the briefing, and the outgoing custody sergeant had prepared comprehensive notes about each detainee. In the morning handover, the outgoing DDO briefed the incoming DDOs about some potentially aggressive detainees and those who were particularly vulnerable and might benefit from extra attention. The handovers were conducted at the booking-in desk, so were video- and audio-recorded.

4.20 The NSPIS custody record system incorporated a pre-release risk assessment (PRRA) prompt for custody sergeants to complete before closing the record. A leaflet with information about support agencies was routinely given to detainees leaving custody. We saw one custody sergeant at Charing Cross telling a detainee about agencies she felt might be useful to him, encouraging him to make contact, and some custody sergeants offered to make referrals on behalf of detainees. However, other PRRAs were less satisfactory and some detainees we saw being bailed by the 'virtual court' were not subject to the process at all. In our custody record analysis, most PRRAs indicated that no risks had been identified. In cases where we

considered there to be a high likelihood of risk, none had been described. There were several examples of detainees, including a young person, being released late at night or in the early hours of the morning for whom the PRRA indicated no risks, and with nothing in the record about how they would get home.

Recommendations

4.21 The quality and consistency of initial risk assessments should address the potential risks identified.

4.22 The quality and consistency of pre-release risk assessments should include detainees released by the virtual court.

Housekeeping point

4.23 Custody sergeants at Belgravia should maintain better control of the number of other staff waiting in the booking-in area.

Use of force

4.24 Most detainees we observed being brought into custody were not handcuffed on arrival. Arresting officers were asked if they had used restraints and, if so, sergeants checked detainees' wrists for marks. Custody sergeants told us that officers were encouraged to assess whether or not it was appropriate to remove handcuffs before detainees were brought into custody.

4.25 Although there was a use-of-force form, sergeants we spoke to at Charing Cross were unaware of it and told us that its use had been discontinued. At Belgravia, we saw officers trying to walk a detainee to a cell, even though he was handcuffed to the rear and wore leg restraints. He was subsequently dragged into the cell on the tips of his toes, yet the custody record stated that he had been carried there. Custody sergeants and DDOs told us that when force was used they recorded it in the custody record, prepared a statement (an MG11) and noted the incident in their pocket books. This meant that the use-of-force data would only be retrievable if the custody record was checked, thereby removing the potential to use lessons learned from such incidents to inform staff safety training, monitor trends and act on any concerns about use of force. All staff had been trained in approved safety techniques and received annual refresher training.

4.26 The approach to strip-searching varied widely between custody sergeants. We saw some sergeants appropriately authorising the strip-searching of three detainees: one who had a warning marker for secreting items on his person and the other two because of the nature of their alleged offences (possession of drugs). The grounds for strip-searching three detainees we saw during a night visit to the Charing Cross custody suite were less satisfactory and potentially in breach of PACE. They were brought into the custody suite intoxicated and were strip-searched on the grounds that the risk assessment could not be completed because they were uncooperative. PACE code C specifies that strip-searching should be conducted if the officer reasonably considers that the detainee might have concealed an article that they are not permitted to keep. The strip-search was conducted in a cell which was monitored by CCTV and therefore visible on the monitor behind the custody desk.

Recommendations

4.27 Strip-searching should be appropriately authorised, comply with PACE code C and be the subject of effective data collection to identify appropriate use.

4.28 Strip-searching should be carried out in private; when conducted in a closed-circuit television-monitored cell, the monitor should be switched off.

Physical conditions

4.29 At Charing Cross, most of the cells were reasonably clean but there was graffiti on some of the bed plinths. The corridor leading to some of the cells had ingrained dirt on the floor. Some of the cells appeared to be considerably colder than others but staff told us that they were unable to control the temperature of the cells and provided detainees with blankets on request. We saw the cleaner at this custody suite cleaning empty cells thoroughly each morning and recording which cells had been cleaned. There were no wash basins in the cells and detainees had to ring the cell call bell to access the communal washbasins. The cells had very little natural light but staff turned on the lights when they were occupied by detainees.

4.30 At Belgravia, the cells were appropriately heated and ventilated and were in a reasonable condition, although there was some ingrained dirt in the corners. Cells were cleaned daily, although if a cell was occupied when the cleaners were on site, it would not be cleaned. This meant that cells that were occupied on consecutive days or weeks would not be cleaned throughout this period.

4.31 The booking-in areas on both floors at Charing Cross were tidy and well ordered. We saw detention staff making their daily checks of the cells and detention rooms, and also the emergency life-saving equipment. This included checking cell call bells, the quality of mattresses and pillows, ventilation and ligature points. On one day during the inspection, 19 cells on the first floor were occupied, which meant that only nine were subjected to a daily check. During a night visit at Charing Cross we saw detainees being moved from one cell to another, apparently without the cells being checked between occupancies. We observed custody staff responding promptly to cell call bells.

4.32 Staff received mixed responses to their requests for emergency repairs but issues that kept cells out of operation were prioritised. Despite a notice at the entrance of the cell blocks stating that staff should not access the cell blocks without the authority of the custody officer, and only in the company of custody staff, we saw non-custody staff being handed cell keys and going to cells to remove detainees for interview or to speak to them.

4.33 Both suites had a fire evacuation policy and fire safety audits had been completed in the current year, but there was no record of fire evacuation exercises. A sealed fire evacuation box containing the policy, handcuffs and paperwork was located under the booking-in desk on both floors at Charing Cross, and custody staff were aware of its location. At Belgravia, there was a fire evacuation box containing sufficient sets of rigid handcuffs, but not all staff were aware of it and not all of them knew the emergency evacuation routes. A fire evacuation policy was in place but during the inspection it took staff considerable time and effort to find the file in which it was contained. The next day, this situation had been remedied and a laminated copy was displayed in the booking-in area. No staff we spoke to could recall taking part in a fire evacuation drill and we found no record of any drills being carried out.

Recommendations

4.34 All cells should be cleaned daily and be kept free of graffiti.

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

4.36 Fire evacuation drills should be carried out regularly and records kept.

Housekeeping point

4.37 Cells should be checked between uses.

Detainee care

4.38 At both suites, each cell contained a mattress and pillow, which were not wiped clean between uses. There was a good stock of clean blankets, which were distributed during the daytime only on request. The communal hand washbasins were reasonably clean. At Charing Cross, toilet paper was given to detainees on entry to the cells, subject to a risk assessment. At Belgravia, detainees had to ask for toilet paper. Images of toilet areas on CCTV monitors were obscured.

4.39 In our custody record analysis, only three (10%) detainees had been offered a shower or wash while in custody, all of whom had accepted. In our review of 10 custody records from Paddington Green, none of the detainees had been offered a shower. The showers at Charing Cross and Belgravia were clean but not private. At Charing Cross, the shower was located in a small alcove, so detainees could not be seen from the corridor while in the shower but could be seen if they were getting dressed near the bench. There were no cotton towels and detainees were expected to dry themselves with paper towels. At Belgravia, we saw three detainees being prepared for the journey to court. None was offered a shower; they all asked if they could have a wash and were allowed to do so.

4.40 Toiletries such as toothpaste and soap were available, and also a variety of sanitary products for women, although these were not routinely offered. There were stocks of replacement clothing at both suites, including track suit bottoms, T-shirts, paper suits and plimsolls, and we saw some detainees in replacement clothing and shoes. However, there was no replacement underwear. Subject to a risk assessment, detainees could have clothing brought in by family members.

4.41 Detainees were supplied with meals from the police station canteens at both suites. They were offered a vegetarian or non-vegetarian option. When the canteen was closed, custody staff had a supply of microwave meals, which met a range of dietary and religious needs. The kitchen at Charing Cross was well maintained and the microwave oven was clean. Tea, coffee and water were available and offered regularly. At Belgravia, catering arrangements were unsatisfactory. The microwave oven was faulty, which meant that detainees going to court were not given breakfast beforehand.

4.42 Custody staff at both suites told us that they distributed meals at recognised mealtimes but would also provide a meal if a detainee said that he or she had not eaten for some time. In our custody record analysis, 24/30 (80%) detainees in our sample had been offered at least one meal while in custody, whereas the remaining six had not; they had all been held in custody for

under seven hours. We saw a vulnerable detainee being given a meal at 10pm during our night visit at Charing Cross.

4.43 There was no exercise yard in either suite. Custody staff said that they had previously taken detainees requesting time in the open air into a caged area near the entrance to the custody suite; however, they said that that this no longer happened as they had been instructed not to take detainees into this area because it was a thoroughfare. A similar caged area at Belgravia contained rubbish, including discarded mattresses and dirty blankets. There was limited reading material available, and nothing in languages other than English, in easy-read formats or for young people. During the inspection at Charing Cross, no reading matter was offered to detainees, and some we spoke to were not aware that it was available. Our custody record analysis found that one detainee had been allowed to keep a book that they had brought in. Visits were not routinely permitted at either suite.

Recommendations

4.44 All detainees held overnight should be offered a shower and shower facilities should be private.

4.45 Suitable alternative clothing should be provided to detainees whose own clothing is inadequate or has been taken away.

4.46 All detainees being taken to court should be given breakfast.

4.47 Detainees, particularly those held for more than 24 hours, should be offered exercise, and exercise yards should be provided that are fit for purpose.

Housekeeping points

4.48 Mattresses should be wiped down between uses.

4.49 Toilet paper should be routinely provided in each cell, subject to risk assessment.

4.50 Cotton towels should be provided to detainees.

4.51 Hygiene packs should be routinely offered to female detainees.

4.52 Replacement underwear should be available at all suites.

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

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 detainees being booked in promptly after arrival at the custody suites. Custody staff told us that there was a 'bedding down' culture, whereby investigations concerning many detainees arrested during the evening were not progressed until the following morning. This was evident during a weekend night visit we conducted at Charing Cross, where there was only one Criminal Prosecution Unit (CPU) officer on night duty. Staff told us that the large number of cases to be dealt with would result in some detainees being kept in custody all night, which was unnecessary as investigations could have been progressed and some detainees released.

5.2 Custody sergeants told us that they occasionally refused to authorise detention, although some said that they had received criticism from senior officers for doing so (see main recommendation 2.33). Arresting officers mostly used the justification of 'prompt and effective investigation' as grounds for arrest, even when there would be little investigation conducted, as in cases of drunk and disorderly behaviour. There seemed little awareness of the revised PACE code G arrest necessity criteria, which require officers to arrest only when voluntary attendance is not appropriate. We saw some limited use of voluntary attendance at Charing Cross. In our survey, 86% of detainees said that they had spent more than 24 hours in the suite, against the 67% comparator. Although we observed custody staff actively liaising with police officers to minimise the time that detainees spent in custody, they were not always able to move investigations forward promptly.

5.3 Custody staff assured us that the suites were not used as places of safety under section 46 of the Children Act 1989.[2] However, we observed a 16- year-old in custody at Belgravia who was arrested at 11.10pm but her AA did not attend until 11.30am the following morning. Our custody record analysis found similar long waits, one being over 14 hours. Custody sergeants made decisions carefully about which detainees might be vulnerable, and they involved health care staff in their assessments. Custody staff contacted social services to confirm the availability of secure PACE beds for young people held overnight who could not be bailed but none we spoke to was aware of any such beds ever having been made available.

5.4 At the time of the inspection, the force adhered to the PACE definition of a child instead of that in the Children Act 1989,[3] which meant those aged 17 were not provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable (see recommendation 2.35). Custody staff told us that they normally tried to use family members as AAs. If they were unsuitable or unavailable, AAs for children and vulnerable adults were obtained from a local social services-operated AA scheme that was staffed by volunteers. Custody staff told us that volunteers attended reasonably promptly during the day, and provided a good service, but they were never available after about 10pm.

[2] 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.

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

5.5 A leaflet explaining detainees' rights in relation to PACE was available and could be printed in a range of different languages from the MPS intranet. However, two custody staff who booked in detainees at Charing Cross were unaware of the translated version. They claimed that they had sometimes resorted to the time-consuming and unnecessary process of getting rights information translated for detainees from internet translation sites. Some detainees at Charing Cross were given copies of rights information that had been repeatedly photocopied and were therefore difficult to read.

5.6 The MPS had recently introduced 'virtual interpreters', who were available for interview purposes via video-conferencing. Detainees were given the choice of using this alternative service or having an interpreter attend in person, which was facilitated. Touch-screen language terminals, mounted on the walls of the booking-in area, were also available at both suites. These displayed questions in the required foreign language, but staff were unaware of what was being asked of the detainee as no English subtitles were available, and the range of preset 'scripts' was too limited. In addition, the terminals had been sited away from the booking-in desks, limiting their suitability for use in booking-in. Staff told us that they did not use them because these problems impeded the flow of verbal information during the booking-in process.

5.7 A professional telephone interpreting service was available via a two-handset telephone, and we saw this in use. At Charing Cross, we observed the booking in of a detainee who was unable to read; even though the suite was very busy, the DDO helpfully asked the arresting officer to read out all the relevant information and then verified that the detainee understood what he was signing for.

5.8 Custody staff reported a good relationship with UKBA staff, a team of whom was based at Charing Cross Police Station. It expedited all foreign national checks of detainees brought into the custody suites during normal working hours. Their onsite presence had led to a reduction in the time spent in police custody for immigration detainees waiting for transport to more suitable facilities, although staff told us that there were delays out of working hours, when contact had to be made with other UKBA offices. Data supplied by the MPS showed that the average length of time that immigration detainees spent in police custody was 15 hours.

5.9 The operation of the virtual courts system at Charing Cross gave considerable cause for concern. Court staff often emailed warrants in remand cases too late for DDOs to book a cellular vehicle to take the detainee to prison on the same day. Delays of two hours or more in sending the warrant were common. Data collected by the MPS showed that in many instances this caused detainees to be held in police custody for one or two nights (and longer at weekends) after being remanded, and they were therefore unable to access their entitlements as remand prisoners (see main recommendation 2.34).

Recommendation

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

Housekeeping points

5.11 Custody sergeants and designated detention officers should be told how they can obtain translated rights information from the MPS intranet.

5.12 Rights and entitlement leaflets should be clearly printed.

Rights relating to PACE

5.13 At both suites, posters reminding detainees of their rights to legal advice, translated into other languages, were prominently displayed. We observed detainees being told that they could read the PACE codes of practice during the booking-in process. Although new copies of the updated code had been issued to the custody suites, we saw that an out-of-date edition had been issued to a detainee at Belgravia. Two of the four interview rooms at Charing Cross had been out of action for several days at the time of the inspection as a result of faulty equipment; this had caused delays in interviewing. At Charing Cross, there was a telephone with a hood in the booking-in area which detainees could use to speak to legal advisers, but it afforded little privacy. A telephone hood had been available at Belgravia but it had been removed after a detainee had used part of it to self-harm, and it had not yet been reinstated. Detainees who declined the offer of legal advice were reminded that they could change their mind at any time.

5.14 Custody records were made available to legal advisers and we were told that detainees who asked for it would be given a copy. All custody staff advised detainees that they could make a telephone call to inform someone of their whereabouts and we saw such calls being facilitated promptly. In our custody record analysis, all detainees had been routinely offered legal advice and half of those in our sample had accepted this offer. In all but one instance it appeared that solicitors had been contacted promptly and stayed in close communication with custody staff. In one case involving an immigration detainee, the individual had accepted the offer of a solicitor but there was no further record of one being contacted or attending custody. Of the 15 detainees who declined the offer of a solicitor, it was unclear whether they had been reminded that they could change their mind at any time and subsequently have a solicitor contacted, although it was noted in inspector reviews that detainees should be reminded of this. Reasons for declining legal advice were not usually recorded in the rights document.

5.15 One 'PACE inspector' carried out reviews of detention for both suites on a shift basis. Most reviews were undertaken in person at the suite where the inspector was based, but many took place remotely at the other suite. At Charing Cross, we observed reviews being conducted in person. The inspectors reminded detainees of their rights and asked about any welfare concerns. However, one inspector did not explicitly state that he was authorising further detention; he told us that this was because it was 'implicit in the process'. Some reviews were undertaken very early – in one case, less than two hours after detention was authorised – to help balance out the workload. Most of the reviews in our analysis of Paddington Green custody records were undertaken too early, after about four hours in custody. Our custody record analysis found that four of the 20 reviews in the sample had been conducted late, with delays of between 30 and 90 minutes. We found several records of detainees who had been reviewed while they were asleep and it had not been recorded if they had been told of the review on waking. One detainee who had been reviewed while he was asleep told us that he had not been informed of it. It seemed that in some reviews conducted by telephone, a DDO was asked to speak to the detainee rather than the inspector dealing with the detainee directly. It is our expectation that the inspector should speak to the detainee personally when conducting a review and not through a third party.

5.16 Court cut-off times were too early, at 1pm for Westminster and Camberwell Magistrates' Courts, although the 3pm cut-off time for the West London Youth Court was more reasonable. A prisoner escort contractor (PEC) was available for transportation for both morning and afternoon courts. If the PEC was unable to meet its contract for transportation to afternoon courts, police officers took detainees in police vehicles to ensure that they did not remain in custody longer than necessary. At Belgravia, we saw a prisoner who had been waiting in custody for almost 20 hours for transportation to prison on a licence recall; staff attributed this delay to the escort contractor.

5.17 We found no problems in the handling of DNA samples.

Recommendation

5.18 Detainees should be informed of any reviews carried out while they were sleeping, and a record of this should be made in the detention log.

Housekeeping point

5.19 The latest copies of the PACE codes of practice should be available to detainees in the custody suites.

Rights relating to treatment

5.20 There were inconsistencies among custody staff in the management of complaints. Some staff told us that complaints could not be taken in custody and that a detainee wishing to complain would be told to go to the police station front desk on release (unless the complaint involved their stay in custody), whereas others said that they would ask the duty inspector to deal with the complaint while the detainee was in custody. Managers told us that they expected all complaints to be taken by custody staff. There was no information available about how to make a complaint.

Recommendation

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

6. Health care

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

Governance

6.1 Health services were provided by the MPS and mental health services by Central and North West London Mental Health Trust. Custody nurses were based in the suites 24 hours a day and supported by on-call forensic medical examiners (FMEs). Recent gaps in nursing staffing had resulted in more frequent reliance on FMEs, with response times sometimes up to four hours. Female detainees were not always able to see a female doctor.

6.2 We saw constructive partnership working between HCPs and custody staff, and most custody staff were complimentary about the contribution of HCPs. Custody nurses were part of the custody shift handovers, although this was due to change shortly with changes to custody staff shift patterns. Verbal handovers between nurses and custody staff were effective.

6.3 Overall governance was reasonable, with an appropriate range of health-specific policies and clinical guidance readily accessible on the force intranet. HCPs and nurse managers were fully engaged in strategic and operational custody meetings, alongside designated clinical review meetings for nurses.

6.4 We were told that either a telephone interpreting service or face-to-face interpreters were used for detainees with limited use of English but no data were collected to confirm this. Formal consent to information sharing with GPs in relation to previous medical history and medications was sought.

6.5 Medication was well managed, with appropriate stock control and audit trails. Controlled drugs (schedule 4 and 5) were counted daily and after administration, and checks were recorded, although there had been some gaps in recording in recent months.

6.6 Custody nurses had received induction training and had access to two training days a year covering key learning, including emergency life support refresher training, safeguarding and management of tuberculosis. Custody nurses had clear management supervision, and line managers offered annual appraisal with clinical supervision.

6.7 The medical rooms in both suites were clean and tidy and apart from the sink taps, complied with infection control. The rooms were only used for health care consultations and for HCPs taking forensic samples. Access to the rooms was restricted to health care staff, with appropriate safekeeping of the keys, including to medication cupboards, and an associated audit trail.

6.8 Resuscitation equipment was kept in both suites and included hand suction, automated defibrillators and oxygen. Daily and weekly checks were scheduled for nurses to complete, but there were some gaps in the recording of these. Defibrillators were also checked by custody staff.

Recommendation

6.9 Detainees should be able to see a health care professional of the gender of their choice.

Housekeeping points

6.10 Controlled drugs checks should be recorded daily and records should be up to date.

6.11 Recording of daily checks of equipment should be consistent.

Patient care

6.12 Custody nurses checked the national strategy for police information systems (NSPIS) custody computer system when coming on duty, to identify detainees who needed medical attention, and also responded to requests from custody staff. Nurses sought advice and prescriptions from on-call FMEs as required. We saw custody staff offering detainees the opportunity to see an HCP.

6.13 We observed several consultations with detainees; they were respectful and clinically appropriate, with attention to key risks such as alcohol withdrawal and the need for increased observations. However, we saw nurses leaving the door open while seeing detainees, even when no risk to their safety had been identified, which compromised confidentiality.

6.14 There was good attention to mental capacity and vulnerability, and we saw a nurse requesting an AA for a young adult with mental health needs.

6.15 Custody nurses recorded onto eCHAPS clinical records, visible only to health care staff, and entered a summary version on the medical referral form, which could be seen by custody staff, protecting the detainee's confidential medical information. The records we reviewed were clear and factual.

6.16 Nurses occasionally attended to victims of crime in urgent or emergency situations, and were aware of the need to ensure that there was no conflict of interest between their role with detainees and any care of victims. Consultations with victims were recorded on paper clinical records and these were stored appropriately in the nurse manager's office.

6.17 Nurses were able to use a range of patient group directions to administer simple pain relief and the first two doses of symptomatic relief for substance use withdrawal symptoms. Arrangements for detainees bringing in prescribed medication were effective. When medication was clearly labelled and identifiable, nurses sought consent from the detainee, contacted his or her GP for faxed confirmation of the prescription and then requested a prescription from the FME on call. When detainees arrived without their prescribed medication, custody staff asked relatives or friends to bring it in. FMEs recorded prescriptions they had written and instructions for medicine administration on the custody medical referral form on the NSPIS custody record. Detainees were given symptomatic relief for the symptoms of opiate withdrawal rather than opiate substitution.

6.18 There was no provision for detainees to obtain a copy of their records. Confirmation of prescribed medication could be made available to their community GP.

Recommendations

6.19 Health care professionals should keep the medical room door closed when seeing a detainee, except when they have identified or been advised of a risk to safety.

Substance misuse

6.20 Westminster Drugs Project workers provided support and intervention for both drug and alcohol problems. They attended both suites daily between 7am and 10pm. Out of hours, a telephone answering service picked up referrals.

6.21 Trigger testing was targeted using police discretion. This meant that there was a risk that detainees with only trigger offences who did not disclose substance use problems could miss the opportunity for referral to substance use services. The decision and reasons not to test were not always clearly communicated before detainees' release.

6.22 Substance use workers had effective mechanisms for contacting local services for follow-up appointments in the community, both for detainees testing positive and for those seeking help on a voluntary basis. Detainees were also given information about local syringe exchange services.

6.23 Young detainees were given information about substance use services in the community while in custody and could be referred to a nearby 'Turning Point' service.

Recommendation

6.24 The decision to test or not, and the reasons, should be clearly communicated to substance use workers, to ensure that detainees can be given appropriate support and advice.

Mental health

6.25 There was a local criminal justice liaison service, with good links between the local courts and the custody suites.

6.26 Registered mental health nurses (RMNs) were available seven days a week, between 9am and 5pm, but there had been some recent rota gaps at the weekends. They contacted or attended the suites first thing each morning to identify detainees needing attention. There were generally positive relationships with custody staff, and RMNs responded quickly to requests to see detainees.

6.27 Where possible, RMNs obtained detainees' previous history from community mental health teams (CMHTs) or GPs. We saw good follow-through of the history of one detainee with his local CMHT which then informed his care while in custody.

6.28 RMNs gave verbal handovers to custody staff but were not able to record directly onto NSPIS; there appeared to be a mixture of recording mechanisms, including dictating to custody staff for the detention log and giving a verbal handover to the custody nurse, who then recorded onto eCHAPS or the medical referral form.

6.29 Out of hours, referrals for mental health support were filtered via the local authority emergency duty team, with sometimes long delays in response to requests for mental health assessments.

6.30 Section 136 of the Mental Health Act 1983[4] was used appropriately, and usually for extreme violence, with very few detainees coming into custody; there were no inappropriate detentions during the inspection. There was a section136 suite at both the Gordon and St Charles Hospitals. MPS data showed that in the previous year, there had been only five admissions to Westminster custody suites under the provisions of section 136 of the Mental Health Act.

6.31 Mental health awareness training had been run in the previous year but not all custody staff were able to recall having received it and there was some evidence of a lack of understanding of mental health needs by a small minority of staff.

Recommendations

6.32 Mental health professionals should directly record the outcomes of their consultations on NSPIS, to inform the clinical record and ensure the safety and continuity of care for the detainee.

6.33 Mental health awareness training should be regular and enable all custody staff to identify and manage the care of detainees appropriately and safely.

[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.

7. Summary of recommendations

Main recommendations

7.1 Booking-in desks should allow effective and private communication between custody staff, detainees and their legal representatives. (2.31)

7.2 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and establish learning for the force. (2.32)

7.3 The Metropolitan Police Service should develop and promote alternative to custody approaches, and custody sergeants should ensure that the 'necessity test' for arrest is properly applied. (2.33)

7.4 The MPS should work with HM Courts and Tribunals Service to ensure that the virtual court system does not result in unnecessarily long stays in police custody. (2.34)

National issues

7.5 Appropriate adults should be available out of hours, given informed consent where necessary, to support children and young people aged 17 and under and vulnerable adults in custody. (2.35)

Recommendations

Strategy

7.6 The borough should work with criminal justice partner agencies to ensure that regular senior management meetings with criminal justice partners are sustained. (3.17)

Treatment and conditions

7.7 There should be sufficient female staff available to attend to the needs of female detainees. (4.9)

7.8 The quality and consistency of initial risk assessments should address the potential risks identified. (4.21)

7.9 The quality and consistency of pre-release risk assessments should include detainees released by the virtual court. (4.22)

7.10 Strip-searching should be appropriately authorised, comply with PACE code C and be the subject of effective data collection to identify appropriate use. (4.27)

7.11 Strip-searching should be carried out in private; when conducted in a closed-circuit television-monitored cell, the monitor should be switched off. (4.28)

7.12 All cells should be cleaned daily and be kept free of graffiti. (4.34)

7.13 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.35)

7.14 Fire evacuation drills should be carried out regularly and records kept. (4.36)

7.15 All detainees held overnight should be offered a shower and shower facilities should be private. (4.44)

7.16 Suitable alternative clothing should be provided to detainees whose own clothing is inadequate or has been taken away. (4.45)

7.17 All detainees being taken to court should be given breakfast. (4.46)

7.18 Detainees, particularly those held for more than 24 hours, should be offered exercise, and exercise yards should be provided that are fit for purpose. (4.47)

Individual rights

7.19 The Metropolitan Police Service should engage with the local authority to ensure the provision of safe beds for young people who have been charged but cannot be bailed. (5.10)

7.20 Detainees should be informed of any reviews carried out while they were sleeping, and a record of this should be made in the detention log. (5.18)

7.21 Detainees should routinely be told how to make a complaint, in line with the Independent Police Complaints Commission statutory guidance, and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.21)

Health care

7.22 Detainees should be able to see a health care professional of the gender of their choice. (6.9)

7.23 Health care professionals should keep the medical room door closed when seeing a detainee, except when they have identified or been advised of a risk to safety. (6.19)

7.24 The decision to test or not, and the reasons, should be clearly communicated to substance use workers, to ensure that detainees can be given appropriate support and advice. (6.24)

7.25 Mental health professionals should directly record the outcomes of their consultations on NSPIS, to inform the clinical record and ensure the safety and continuity of care for the detainee. (6.32)

7.26 Mental health awareness training should be regular and enable all custody staff to identify and manage the care of detainees appropriately and safely. (6.33)

Housekeeping points

Strategy

7.27 The borough should review the custody-specific link on the borough operational command unit intranet pages. (3.13)

7.28 The borough should work with the independent custody visitor scheme volunteers to eradicate delays in their admission to custody suites. (3.17)

7.29 There should be management oversight of refresher training, to ensure that all staff working in custody receives it at least annually. (3.19)

Treatment and conditions

7.30 Confidential conversations about detainees should take place only where they cannot be overheard by non-custody staff and visitors. (4.10)

7.31 Staff should familiarise themselves with the use of equipment such as hearing loops. (4.11)

7.32 Staff should be briefed about the correct way of searching transgender detainees, in accordance with Annex L of the PACE codes of practice C. (4.12)

7.33 Custody sergeants at Belgravia should maintain better control of the number of other staff waiting in the booking-in area. (4.23)

7.34 Cells should be checked between uses. (4.37)

7.35 Mattresses should be wiped down between uses. (4.48)

7.36 Toilet paper should be routinely provided in each cell, subject to risk assessment. (4.49)

7.37 Cotton towels should be provided to detainees. (4.50)

7.38 Hygiene packs should be routinely offered to female detainees. (4.51)

7.39 Replacement underwear should be available at all suites. (4.52)

7.40 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy. (4.53)

Individual rights

7.41 Custody sergeants and designated detention officers should be told how they can obtain translated rights information from the MPS intranet. (5.11)

7.42 Rights and entitlement leaflets should be clearly printed. (5.12)

7.43 The latest copies of the PACE codes of practice should be available to detainees in the custody suites. (5.19)

Health care

7.44 Controlled drugs checks should be recorded daily and records should be up to date. (6.10)

7.45 Recording of daily checks of equipment should be consistent. (6.11)

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Nicola Rabjohns	HMIP health services inspector
Jan Fooks-Bale	Care Quality Commission inspector
Rachel Murray	HMIP researcher
Alissa Redmond	HMIP researcher