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

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by

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Ashley House
Monck Street
London SW1P 2BQ
England

Contents

1. Introduction

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

The inspection looked at the custody suite at Heathrow police station within the Metropolitan Police Service (MPS). Strategic oversight of the suites was provided centrally by the MPS Criminal Justice Directorate within the Territorial Policing department, which seeks to ensure consistency in custody provision across all London boroughs. Day-to-day management of custody was delegated to the operational command unit commander.

There was clear commitment to custody provision by the operational command unit commander, although some key management posts were vacant. Staffing was a mixture of permanent and temporary staff, and not everyone working in custody was adequately trained or refreshed. There was some good partnership working. As we have found elsewhere, there was a lack of appropriate monitoring of the use of force, both locally and London-wide.

The new prisoner escort service was causing delays and police facilities were being inappropriately used to hold remanded prisoners. The facilities at Heathrow were modern and well maintained. Interactions with detainees were generally appropriate but there was limited attention to diversity. Some risk assessment and management arrangements were inconsistent and the management of health and safety issues needed to be improved. Some basic hygiene needs were only provided when requested and not as a matter of course.

An appropriate balance was maintained between progressing cases and the rights of individuals, and the Police and Criminal Evidence Act (PACE) was adhered to. Legal advice was readily available. Juveniles and vulnerable adults were well served by an appropriate adult scheme during the day but the lack of a night-time service or local authority PACE beds led to some juveniles being unnecessarily detained overnight. Procedures for detainees to make complaints were confusing.

Health care provision was adequate and medicines management acceptable. The attendance of forensic medical examiners was sometimes subject to delay. Substance misuse services were adequate to meet the low demand. Mental health diversion services were well developed and custody was rarely used as a place of safety under the Mental Health Act.

Overall, custody provision in Heathrow was generally sound. This report sets out a small number of recommendations that we hope will assist the MPS and Metropolitan Police Authority to improve the facilities further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

Sir Denis O'Connor
HM Chief Inspector of Constabulary
November 2011

Nick Hardwick
HM Chief Inspector of Prisons

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

2. Background and key findings

2.1 The Metropolitan Police Service (MPS) operates 53 custody suites, 24 hours a day, to deal with the majority of detainees arrested during normal daily policing. A further 20 are reserved as 'overflow custody suites' and are used for various operational purposes. These include: charging centres for football matches, a fallback when maintenance work requires closure of another 24-hour suite, other operational demands over and above custody core business and Operation Safeguard (overflow from prisons), when activated. In total, the MPS has 74 custody suites designated under the Police and Criminal Evidence Act 1984 (PACE) for the reception of detainees.

2.2 This unannounced inspection was conducted at the police custody suite in the MPS operational command unit (OCU) of Heathrow. We examined force-wide and OCU custody strategies, as well as treatment and conditions, individual rights and health care in the custody suite. Heathrow custody suite had 30 cells and was open 24 hours a day. It had received 2,674 detainees between 1 January 2011 and 27 September 2011. In the same period, 180 immigration detainees had been held at the custody suite.

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

Strategic overview

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

2.5 Strategic oversight of custody within the command unit was good, although some key management posts were vacant. Heathrow was a new custody facility. There was a mixture of permanent and temporary shift relief staff, and difficulties had been experienced in recruiting sufficient designated detention officers (DDOs). Managers were not clear if all staff working in custody had been trained and no refresher training was offered. Dip-sampling of custody records took place. Partnership arrangements were well developed, particularly concerning mental health.

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

Treatment and conditions

2.6 Problems with the new prisoner escort contract service were resulting in delays and the use of police custody for people who should have been held in prison, some of whom were extremely vulnerable. Staff interactions with detainees were mainly respectful. Awareness of diversity issues was mixed. Professional interpreting services were generally used when needed, although not in all cases.

2.7 Risk assessments were carried out when detainees arrived in custody and the quality of these was variable, although risk management appeared to be proportionate. We had concerns about the quality of rousing checks. Handovers between shifts took place but were inadequate. Non-custody staff had unrestricted access to detainees in cells. There was no monitoring of use of force or the quality of prisoner escort records (PERs). The physical conditions were good. Detainees were not routinely told how to use cell call bells but these were responded to promptly.

2.8 Detainees were provided with mattresses, pillows and blankets. Showers were rarely facilitated. The toilet area in cells was obscured on the closed-circuit television (CCTV) monitors and detainees were routinely provided with toilet paper. There was a good supply of replacement clothing. Adequate food and drinks were provided. Reading materials were limited and exercise rarely facilitated.

Individual rights

2.9 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. The management of DNA and forensics was good.

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

2.11 Relatives or friends were usually called on to act as appropriate adults (AAs) for juveniles and vulnerable adult detainees. When this was not possible, there were reasonable options available to provide an AA during the day but not out of hours. Juveniles who could not be bailed were held in police custody overnight.

2.12 Detainees were not routinely told how to make complaints and the arrangements for taking them were inadequate.

Health care

2.13 Primary health services were adequate but there were too many delays in the arrival of forensic medical examiners (FMEs) once called. Clinical governance arrangements for FMEs were unsatisfactory.

[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.

2.14 Medicines management arrangements were acceptable and medical rooms good. Detainees could continue to take prescribed medication while in custody. Resuscitation equipment was available and custody staff were trained in its use. The need for substance misuse services was minimal but there was a process for referral to a service. Mental health services were well developed and few detainees were held under section 136 of the Mental Health Act 1983. [4]

Main recommendations

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

2.16 Records of rousing should be kept for all detainees under the influence of alcohol or drugs, and observational cell visits should be recorded, and made in person and not through the closed-circuit television and intercom systems.

2.17 Access to telephone interpreting services for detainees who are not fluent in English should not be unduly restricted.

[4] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

3. Strategy

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

3.1 The MPS had a CJD, led by a commander within territorial policing headquarters and a superintendent was responsible for day-to-day management. Heathrow police station was the base for the OCU responsible for aviation security. Responsibility for day-to-day management of Heathrow's custody suite and delivery of services had been devolved to the OCU commander, who was a chief superintendent. Heathrow police station is situated within the borough of Hillingdon and shares many services with the borough, including a lead member from the MPA who had no defined lead for police custody matters.

3.2 The CJD had an inspection function for audit and compliance, health and safety and the implementation of Safer Detention and Handling of Persons in Police Custody 2006 (SDHP) guidance. The commander sat on the programme board for SDHP and was focused on ensuring an emphasis on 'professionalising custody'.

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

3.4 The majority of funding for the OCU came from the British Airports Authority (BAA), and the custody suite dealt with people arrested in Heathrow airport.

3.5 There was positive and strong personal leadership from the OCU commander and the OCU senior management team (SMT), with a clear commitment to custodial provision. There was a well-defined command structure from the OCU commander down to the custody manager, who was a sergeant. SMT members paid regular visits to the custody suite, with staff reporting good visibility of the SMT in custody. At the time of the inspection, however, there were vacancies in the role of chief inspector support and station inspector. This did not seem to be causing any adverse effects on custody provision and we were assured that these posts would be filled in the near future.

3.6 The CJD had facilitated an organisational self-assessed risk register for all MPS custody suites. The OCU commander had ownership of the risks and had introduced measures to mitigate them. We found that these measures had been put into practice, with a few exceptions.

3.7 Custody issues were discussed by exception at SMT level, at monthly management review meetings, and there were weekly meetings between the custody manager and station inspector (when in post). The custody manager attended bimonthly meetings hosted by the CJD. There were no formal meetings between custody staff, such as a custody user group.

3.8 The suite was staffed by a mixture of permanent custody sergeants during the day and sergeants were deployed from operational patrol teams at night. All DDOs, police constable (PC) gaolers and sergeants performing the role of custody officer had received MPS-approved

custody training, which was delivered corporately, although refresher training was not provided. Staff worked 12-hour shifts in custody. Custody sergeants were line-managed by their operational patrol team inspector, who was also responsible for PACE reviews. There was one permanent DDO, with plans to increase this to four. PC gaolers, deployed from operational patrol teams, were widely used. They received only minimal training for the role; they were required to complete a computer-based training package before working in custody but the quality assurance of this process, and the system for ensuring that only trained PCs were posted into custody, was not robust or clear (see main recommendation 2.15). The DDO and PC gaolers were supervised by their team's custody sergeant. All staff received annual first-aid and personal safety refresher training, which was delivered centrally.

3.9 The custody suite was underused, with a relatively low throughput of detainees, and staffed accordingly. In the event of an unexpected increase in the number of detainees, the OCU commander had empowered custody officers to close the suite to new detainees when they felt that they had reached a safe limit. We were told that the MPS was considering using Heathrow custody suite to process detainees from surrounding boroughs. Although staffing was adequate, the OCU would need to review staffing levels and shift patterns in the event of a sustained increase in detainee throughput.

3.10 Partnership arrangements were described as good, with active engagement with relevant criminal justice and health partners and the UK Border Agency (UKBA).

3.11 There was an MPA lead for the ICV scheme, which was viewed by all parties as an important independent oversight mechanism. ICVs from the Hillingdon panel visited Heathrow custody suite regularly. They had a good record of visits, meeting their target number in the previous year. They prepared a feedback report after each of their visits, and summary reports for quarterly ICV panel meetings were produced. Issues of concern identified by ICVs were addressed either immediately by the custody sergeant or in the longer term by the custody manager. Both the ICV coordinator and custody manager reported good relationships between ICVs and custody staff, and the custody manager regularly attended ICV quarterly meetings.

3.12 There was a good, centrally managed process for the recording of successful interventions in custody. They were initially reviewed and actioned by the custody manager before being sent to the CJD for analysis and fed into organisational learning. Newsletters from the CJD provided information and advice on detainee management and identified health and safety learning points gleaned from successful interventions and near misses, including lessons learned from Independent Police Complaints Commission (IPCC) publications. The newsletters were sent to all custody-trained staff by the custody manager.

3.13 Quality assurance checks were carried out by the custody manager, who was required to dip-sample approximately 10% of custody records per month. These checks followed a set checklist and included dip-sampling of CCTV recordings to cross-reference against a selection of custody record entries. When areas for development were identified, these were fed back to the relevant member of staff by the custody manager. When trends were found, they were brought to the attention of all custody-trained staff by the custody manager. However, there was no dip-sampling of PER forms, to ensure that risk and vulnerability data were accurately recorded to inform other agencies; we discovered that the carbonated copies of these forms were frequently destroyed shortly after the detainee had been transferred.

Recommendation

3.14 The operational command unit (OCU) should ensure that prisoner escort records are included in dip-sampling arrangements.

4. Treatment and conditions

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

Respect

4.1 Detainees were transported to the custody suites in both police and Serco Wincanton vehicles. Those we looked at were clean and in good condition. Serco Wincanton had recently taken over the contract for police detainee movements to and from custody in London and the South-East. At the time of the inspection, there were problems with this and, as a consequence, 'prison lock-out' prisoners were held overnight and over the weekend in police custody suites, including Heathrow. Some of these were particularly vulnerable and the conditions in police custody suites were unsuitable for them. There were also delays in detainee movements from custody to court (see paragraph 5.14 and recommendation 5.19). We were told that the MPS was liaising with Serco Wincanton at a senior level to resolve these problems.

4.2 We observed custody staff to be professional and respectful in their dealings with detainees, and occasionally exceeded normal procedures in order to meet their requirements. For example, one detainee was seen to be distressed in her cell and the custody officer allowed her to sit in the main suite.

4.3 We were told that most police officers working in the OCU were male and firearms trained, and, although they did not carry firearms in the custody suite, the uniform that they wore included firearm holsters and was militaristic in appearance. We considered that this might have been intimidating to some detainees.

4.4 Although the nature of the suite meant that many different nationalities and cultures passed through it, the diverse needs of detainees were not met adequately. A prayer mat and holy books were available but a Muslim detainee we spoke to did not know this. There was no signage in cells or other rooms indicating the direction of Mecca for prayer purposes.

4.5 We were told that the number of children or young people passing through the custody suite was extremely low. Staff told us that they felt de-skilled in dealing with such detainees. All female detainees were asked during the booking-in process, if they would like to see a female officer.

4.6 A custody sergeant told us that he had used a signer when booking in a detainee who was deaf. A hearing loop was also in place. The custody suite was not usually busy and some effort had been made to provide screening, so privacy at the booking-in areas was not a serious issue. Adapted cells were available for detainees with disabilities.

Recommendation

4.7 Staff should receive awareness training in child protection and safeguarding.

Housekeeping point

4.8 Directional signs should be provided to aid Muslim prayer.

Safety

4.9 All detainees were subject to a risk assessment. Our custody record analysis seemed to indicate that the individuals detained were mainly low risk, so risk assessments, although clear, were mostly brief. When an individual was thought to present a higher risk, assessments generally contained a good level of detail but it was unclear from the comments in some custody records whether adequate measures were put in place to manage the risk assessed. Detainees we saw being booked in appeared to undergo a detailed risk assessment, although it was not obvious from our observations or the custody record analysis that use was made of the Police National Computer or force intelligence systems to aid risk assessment. We saw custody officers making use of the information on PER forms for those arriving from prison or other police custody.

4.10 An anti-ligature knife was located behind the custody suite desk but not all custody staff carried one.

4.11 All cells were monitored by CCTV, which could be viewed from the custody desk, but we were assured that there was no over-reliance on this as a substitute for observation. However, our custody record analysis revealed an individual who had been brought into custody heavily intoxicated and placed on 'constant observation', seemingly via CCTV. The custody log entries suggested that some level of rousing had taken place intermittently but this was not recorded routinely, and there was further evidence of 'cell visits' being conducted via intercom (see main recommendation 2.16). We also came across four examples where observation levels had not been met, or it was not clear from the detention log that they had been adhered to. However, staff we spoke to understood the need for effective rousing checks for detainees thought to be under the influence of drink or drugs, and there was *an aide memoire* to this effect affixed to most cell doors. The handover between shifts was good but we observed this being done in the presence and hearing of detainees.

Recommendations

4.12 The Police National Computer and force intelligence systems should be consulted to aid all risk assessments, and detainees' custody records should be endorsed to this effect.

4.13 All custody staff should carry anti-ligature knives.

4.14 The handover between shifts should not take place in the hearing of detainees.

Good practice

4.15 *An* aide memoire *to remind staff to rouse intoxicated detainees was affixed to most cell doors.*

Use of force

4.16 During the inspection, only detainees who were being transported by the prisoner escort service were seen to be wearing handcuffs. We were told that most other detainees did not arrive in handcuffs and that those who did were handcuffed for legitimate and proportionate reasons.

4.17 The use of force was recorded by custody staff in their custody records and by police officers in their evidential pocket note books but it was not collated at a local or force-wide level, so there was no management information accessible.

Recommendation

4.18 The Metropolitan Police Service (MPS) should collate the use of force and examine it for trends in accordance with the Association of Police Officers policy and National Policing Improvement Agency guidance.

Physical conditions

4.19 The custody suite was modern and well maintained, having opened in April 2011. All cells and communal areas were clean and bright, appropriately ventilated, in good decorative order and free of graffiti, and we found no ligature points in cells. Cleaning schedules were strictly adhered to. Staff reported a few ongoing snagging issues with the custody suite but these were in the process of being rectified. There was an enforced no-smoking policy. In our survey, all indicators relating to the physical condition of the custody suite were better than the comparators, particularly concerning cleanliness, which 64% of respondents rated as good, against a comparator of 31%.

4.20 Custody staff were expected to carry out daily checks of the suite, to identify health and safety, maintenance and cleanliness issues. The checklist used for these checks was provided by the custody directorate and was used throughout the MPS. Although we were told that these checks took place, we found little recorded evidence to support this. For example, the daily check sheet register had details of checks for the three days before the inspection and a few other random dates from the previous three months. All other records were missing and could not be located. The custody manager carried out a weekly and monthly check of the facilities, along with the health and safety manager and facilities manager. These were recorded and stored in the custody suite.

4.21 All cells were equipped with call bells and an intercom system (see also paragraph 4.11). Some detainees we spoke to told us that the call bell system had not been explained to them, although, in our survey, 38% of respondents said that it had been explained to them, which was better than the 22% comparator.

4.22 Custody staff were aware of the fire evacuation procedure and cited a false alarm that had resulted in a partial evacuation a couple of months earlier. This had replaced a planned fire drill.

4.23 There were no keys to the cells; they were opened by means of a code and the swiping of an officer's warrant card. This meant that *any* officer could gain access to the cells, without going through the custody staff. During the inspection, we saw non-custody staff visiting the cells,

mainly to take a detainee there or to bring him/her out. We considered that it was less likely that these officers could adequately explain cell processes to a detainee, and that the care of detainees, once booked in, should be the responsibility of custody staff alone.

4.24 There were plenty of interview rooms and they were in excellent condition. One was equipped for use as a virtual court but the facility was not in use. The cell intercom system enabled telephone calls from solicitors to be put through to detainees in their cells but we were told that the system was never used for telephone calls because it was difficult to operate.

Recommendations

4.25 Health and safety checks of the facilities should take place daily.

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

Personal comfort and hygiene

4.27 All cells contained a mattress and a pillow, which were wiped down between uses. Blankets were available on request and always provided at night. There was a good supply of clean blankets available and a clear laundering process.

4.28 Female hygiene packs were available but this was not obvious and they were supplied only on request; our custody record analysis did not reveal any packs being offered.

4.29 Each cell had a toilet, which was obscured on the CCTV system, and hand-washing facilities. Toilet paper and paper towels were provided in all cells. There were excellent showers in the suite, providing sufficient privacy, although they were seldom used, usually only on request. In our survey, no prisoners reported having been offered a shower, and this was reflected in our custody record analysis. Only paper towels were available for those who did shower. A good selection of replacement clothing was available, including plimsolls, but no underwear.

Recommendation

4.30 All detainees held overnight, or who require one, should be offered a shower.

Housekeeping points

4.31 All female detainees should be offered a hygiene pack on arrival.

4.32 Replacement underwear should be made available.

4.33 Cotton towels should be issued.

Catering

4.34 Most meals were provided from the police station canteen. When this was not possible, microwave meals were provided, with halal and vegetarian options available, although not all DDOs/PC gaolers were familiar with the options available. One Muslim detainee we spoke to

was under the impression that he had not been served a halal meal. In our survey, 26% of respondents said that the food offered was suitable for their dietary requirements, which was worse than the 44% comparator.

4.35 Although we saw hot and cold drinks being provided at regular intervals, in our survey only 62% of respondents, worse than the 83% comparator, said that they had been offered drinks.

Housekeeping point

4.36 Custody staff should be aware of the dietary needs of Muslim detainees.

Activities

4.37 There was a large, light exercise room in the custody suite but it was not in the open air. We were told that this room was used on request only and no member of staff could recall it ever being used. This was corroborated by our survey, in which no prisoners said that they had been offered a period of outside exercise, and in our custody record analysis. No detainee we spoke to knew of the existence of this room.

4.38 There was a small selection of reading material available, mostly books, but only in English, although one custody officer indicated that he had printed excerpts from foreign language newspapers to keep detainees occupied. Reading material was available only on request, and our custody record analysis failed to find any detainee who had been offered anything to read.

4.39 Overall, the suite was well equipped but many services were on 'request only'; in the words of one custody officer: *`I suppose by asking "do you want a shower" you are making work for yourself, as they would need to be supervised and we would not do that if we were busy`.*

Recommendation

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

Housekeeping point

4.41 Reading materials suitable for a range of detainees, including young people and those who are not fluent in English, should be made available.

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 staff asking arresting officers detailed questions about the reasons for, and purpose of, arrest, although we were told that it was rare that detention was refused. There seemed little impetus to use alternatives to detention, such as voluntary attendance.

5.2 On booking-in, detainees were told that they could inform someone of their arrest, and we saw staff arranging their telephone calls promptly. However, our custody record analysis found that in several cases there was no record that staff had attempted to contact the person nominated by the detainee. There was a small cubicle in the booking-in area where detainees could make telephone calls with a degree of privacy but we were told that it was rarely used.

5.3 The MPS told us that it had a good relationship with UKBA, which, in view of the location of the custody suite, was essential. According to MPS data, the average number of immigration detainees held was 20 per month, and the average time spent in detention was 10 hours, which was favourable in comparison with other forces. A professional telephone interpreting service was available via two-handset telephones, and we saw it being used. However, we found that custody staff were sometimes reluctant to use telephone interpreters, even when there was a clear need. For example, during the inspection, a female detainee was brought to the custody suite from HMP Holloway. A telephone interpreting service was used for booking her in. However, over the next couple of hours she became distressed and began to look unwell. With the help of an interpreter, she managed to convey that she had a headache and that she wanted to talk to the custody sergeant. The custody sergeant contacted the FME but was reluctant to allow the detainee to talk to her via the telephone interpreting service; when we asked why, we were told that it was expensive (see main recommendation 2.17).

5.4 Leaflets about legal rights were available in several languages and were easily accessible. However, none had been adapted for detainees with learning difficulties or limited literacy. There was little other information available in languages other than English.

5.5 Staff assured us that they would not allow the custody suite to be used as a place of safety under Section 46 of the Children Act 1989.

5.6 We observed staff asking detainees if they had had any dependency obligations and checking that suitable arrangements had been made.

5.7 The custody record system incorporated a pre-release risk assessment prompt which custody sergeants had to complete. Although the pre-release risk assessments we observed were basic, staff told us that they considered how detainees about to be released would get home. This was supported by custody records, one of which showed that police officers had transported a group of detainees released during the night back to where their car had been left. Detainees who were considered vulnerable were issued with a leaflet listing a range of national and local welfare organisations.

Recommendations

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

5.9 Custody sergeants should ensure that reasonable efforts are made to contact the person that a detainee nominates when they are booked in and that contact attempts are properly noted in the custody record.

Rights relating to PACE

5.10 We saw detainees being told about the PACE codes of practice and being offered it to read during booking in, although the most recent amendments did not seem to be available. A poster displayed in the booking-in area reminded detainees of their right to legal advice. When detainees declined a solicitor, we saw staff assuring them that they could change their mind later if they wished. In our custody record analysis, the reason given for refusing legal advice had been recorded in only 19% of cases.

5.11 Custody records showed that there had been some late entries of inspector reviews of detention. We saw a review that comprised a brief conversation through the cell door hatch. We found that one detainee had been asleep during the reviews and there was no indication that he had received a reminder about his rights on waking. Another detainee who could not speak English had been reviewed and the inspector had noted that he was to be reminded of his rights during an interview due to take place later; the interview had not taken place, so the detainee had not been reminded, despite spending another five hours in custody.

5.12 We found no examples of detainees being interviewed while under, or thought to be under, the influence of alcohol or drugs.

5.13 Juveniles were rarely held in the custody suite; custody sergeants told us that when this happened, they tried to use family members as AAs. When this was not possible or appropriate, they would contact the local Social Services, which, they thought, would provide a service seven days a week. However, the nature of these arrangements seemed vague and we were not assured that it would always be possible to obtain an AA for a juvenile on the rare occasions that one might be needed. The suite had access to a voluntary-led scheme located in the neighbouring borough of Hillingdon which provided AAs for vulnerable adults. Staff told us that it operated a good service, from 7am to 11pm. 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] Local authority beds for juveniles were apparently almost never available.

5.14 The court cut-off time for the local magistrates' court was around 2pm on weekdays. However, because of the nature of the custody suite, detainees were taken to various courts in London and elsewhere. We witnessed long delays in getting detainees to court. A new escort contract, with Serco Wincanton, had started in August 2011 and escort providers and custody staff alike reported undue delays under the operation of the contract. We noted that escorting vehicles did not arrive until mid-morning to convey detainees to court for 9am hearings. A further consequence of the new contract was the daily occurrence of prisoners being locked out of Prison Service establishments due to escort vehicles arriving at the sites after 7pm, leading to police cells being used unnecessarily for prisoners. Escorting staff reported that they often had

[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.

to wait several hours in court cells or in vans while spaces were found in police cells, sometimes as far away as Birmingham and Manchester. We spoke to a pregnant detainee who had been subject to such a delay; she had been held overnight and then waited in the booking-in area until 1pm the following day to be taken to a magistrates' court in East London (see also paragraph 4.1).

5.15 The handling and processing of DNA samples was good. There were clear procedures in respect of continuity of evidence and collection of samples.

Recommendations

5.16 Reviews of detention should be timely, conducted with the detainee's involvement whenever possible and be properly recorded.

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

5.18 Senior OCU managers should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court.

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

Housekeeping points

5.20 Adequate stocks of the most recent PACE codes of practice and their amendments should be maintained.

5.21 The reasons why detainees decline the services of a solicitor should always be recorded.

Rights relating to treatment

5.22 Detainees were not routinely told how to make a complaint about their treatment, in accordance with the Independent Police Complaints Commission 2010 statutory guidance, and there was no information about the procedure on display.[6] There was a general expectation from the OCU commander that complaints should be taken while detainees were still in custody but this did not happen in practice, and staff were vague about the arrangements for taking them. There was no clear process for following up complaints if the detainee was remanded in custody.

5.23 The OCU collated information on complaints and examined trends but was unable to extrapolate data and trends relating to complaints made in custody.

[6] IPCC statutory guidance to the police service and police authorities on the handling of complaints, 2010

Recommendation

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

6. Health care

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

Clinical governance

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

6.2 There were two FME rooms in the custody suite, both of which were clean and bright, although the automated lighting system made it impossible to turn the lights off to undertake an optical examination. None of the sharps boxes or the pharmaceutical waste bins were signed and dated on start of use, and the yellow clinical waste bins did not conform to current infection control guidance.

6.3 Most medications were stored in a metal cupboard behind the custody desk, and there was good recording of the use of Schedule 4 and 5 drugs (Misuse of Drugs Act classification). We found some out-of-date medications and naloxone (an opioid antagonist) in an unlocked cupboard.

6.4 The suite had a defibrillator held behind the custody desk and rescu-vacs and lifepack masks were available. Staff had received resuscitation training as part of their firearms training and updates. DDOs were also first-aid trained. The defibrillators were checked each night as part of the documented equipment checks.

Patient care

6.5 On arrival, detainees were asked whether they wished to see an FME. The FMEs for Heathrow also covered three other police stations, and staff told us that it was sometimes difficult to get an FME to attend. Analysis by the MPS CJD revealed that 389 (about 15%) detainees had required or requested an FME since the beginning of 2011, for which only 28 of the records clearly indicated when the FME had arrived, with an average wait of three hours 14 minutes. Our analysis of custody records revealed that eight (27%) detainees had required an FME; the longest wait had been a little over five hours but the average wait had been one hour 30 minutes. In our survey, 36% of respondents said that they had seen an FME, of whom 50% rated the care they received as good or very good, which was better than the comparator. We witnessed an occasion where, despite the detainee requesting to see a doctor, she was prescribed two paracetamol over the telephone; custody staff told us that it was not unusual for this to occur, as some FMEs were reluctant to come to the suite unless it was at the end of their shift.

6.6 In our survey, all respondents who were on prescribed medication said that they had been able to continue taking it while in custody. Medications left by the FME for later administration by custody staff were attached to custody records. Staff made a note on the national strategy for

police information systems (NSPIS) to remind themselves when medications were due. Two members of staff checked the medication and the prescription before it was administered.

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

Recommendations

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

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

Substance use

6.10 In our survey, only 9% of detainees said that they had a drug or alcohol problem. This low figure was further confirmed in our analysis of custody records, where we found that no detainees had requested to see a drug or alcohol worker. During the inspection, we saw one detainee being given substitute medications by the FME, and a leaflet about services available on release, which the custody sergeant encouraged him to access.

6.11 As a consequence of the low number of detainees attending with substance use issues, Central and North West London NHS Trust (CNWLT) operated a paper referral system only. However, this meant that the police could not be sure whether all cases that were referred were followed up. The Trust did not keep data about where referrals had originated from.

Mental health

6.12 In the previous 12 months, 53 detainees from the Heathrow custody suite had been taken to the section 136 suite of CNWLT, at Hillingdon Hospital. The Trust had police liaison and assessment suite protocols in place, which had been developed in collaboration with the police. Police officers adhered to the protocol, which included giving staff at the section 136 suite prior notice of their impending arrival with detainees. We were told that on a few occasions police officers had turned up unannounced with detainees under section 136, to be assessed by hospital staff. This usually occurred when police officers were new and unfamiliar with the process. We were told that, in the year to date, only two detainees had been taken into the police custody suite under section 136.

6.13 Police liaison meetings took place monthly and section 136 admissions were a standing agenda item. Hospital staff told us that the police were helpful and always attended the meetings.

6.14 When a detainee required a mental health assessment while in custody, response times by mental health professionals appeared to vary greatly. In a recent incident, custody staff had

been proactive and a mental health crisis team had seen and assessed the detainee within two hours of being contacted on a Sunday night. However, the first FME to be called that night had taken over two hours to arrive, thus delaying the eventual mental health assessment, and the following morning the FME on call had not attended the suite, merely giving custody staff advice over the telephone about a patient he had not seen.

7. Summary of recommendations

Main recommendations

To the Metropolitan Police Service

7.1 All staff required to work in custody should be adequately trained, including refresher training. (2.15)

7.2 Records of rousing should be kept for all detainees under the influence of alcohol or drugs, and observational cell visits should be recorded, and made in person and not through the closed-circuit television and intercom systems. (2.16)

7.3 Access to telephone interpreting services for detainees who are not fluent in English should not be unduly restricted. (2.17)

Recommendations

To the Metropolitan Police Service

Strategy

7.4 The operational command unit (OCU) should ensure that prisoner escort records are included in dip-sampling arrangements. (3.14)

Treatment and conditions

7.5 Staff should receive awareness training in child protection and safeguarding. (4.7)

7.6 The Police National Computer and force intelligence systems should be consulted to aid all risk assessments, and detainees' custody records should be endorsed to this effect. (4.12)

7.7 All custody staff should carry anti-ligature knives. (4.13)

7.8 The handover between shifts should not take place in the hearing of detainees. (4.14)

7.9 The Metropolitan Police Service (MPS) should collate the use of force and examine it for trends in accordance with the Association of Police Officers policy and National Policing Improvement Agency guidance. (4.18)

7.10 Health and safety checks of the facilities should take place daily. (4.25)

7.11 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.26)

7.12 All detainees held overnight, or who require one, should be offered a shower. (4.30)

7.13 Detainees held for long periods should be offered outside exercise. (4.41)

Individual rights

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

7.15 Custody sergeants should ensure that reasonable efforts are made to contact the person that a detainee nominates when they are booked in and that contact attempts are properly noted in the custody record. (5.9)

7.16 Reviews of detention should be timely, conducted with the detainee's involvement whenever possible and be properly recorded. (5.16)

7.17 Appropriate adults should be available without undue delay to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.17)

7.18 Senior OCU managers should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.18)

7.19 The MPS should continue to liaise with Serco Wincanton to resolve the recent difficulties with escort arrangements, so that detainees are not inappropriately held in police custody, subjected to long periods in cellular vehicles or unreasonably delayed in their arrival at court. (5.19)

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

Health care

7.21 The response times of forensic medical examiners (FMEs) should be subject to routine monitoring and action taken as required, ensuring that there are no unacceptable delays for detainees in receiving the services of a health care professional. (6.8)

7.22 FMEs should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott principles. (6.9)

Housekeeping points

Treatment and conditions

7.23 Directional signs should be provided to aid Muslim prayer. (4.8)

7.24 All female detainees should be offered a hygiene pack on arrival. (4.31)

7.25 Replacement underwear should be made available. (4.32)

7.26 Cotton towels should be issued. (4.33)

7.27 Custody staff should be aware of the dietary needs of Muslim detainees. (4.36)

7.28 Reading materials suitable for a range of detainees, including young people and those who are not fluent in English, should be made available. (4.42)

Individual rights

7.29 Adequate stocks of the most recent PACE codes of practice and their amendments should be maintained. (5.20)

7.30 The reasons why detainees decline the services of a solicitor should always be recorded. (5.21)

Good practice

Treatment and conditions

7.31 An *aide memoire* to remind staff to rouse intoxicated detainees was affixed to most cell doors. (4.15)

Appendix I: Inspection team

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

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through Heathrow police station, was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The survey was conducted on 23rd September 2011. A list of potential respondents to have passed through Heathrow police station was created, listing all those who had arrived from Feltham, Brentford or Uxbridge Magistrates' court within the past three months.[7]

Selecting the sample

On the day, the questionnaire was offered to 16 respondents; two respondents returned surveys regarding other police stations and one survey was not returned. All of those sampled had been in custody within the previous three months.

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

Methodology

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

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

- to fill out the questionnaire immediately and hand it straight back to a member of the research team;
- have their questionnaire ready to hand back to a member of the research team at a specified time; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Response rates

In total, 13 (81%) respondents completed and returned their questionnaires.

[7] Researchers routinely select a sample of prisoners held in police custody suites within the last two months. Where numbers are insufficient to ascertain an adequate sample, the time limit is extended up to three months. The survey analysis continues to provide an indication of perceptions and experiences of those who have been held in these policy custody suites over a longer period of time.

Comparisons

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

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

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

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

Summary

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

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

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

Police custody survey

Section 1: About you

Q2 Which police station were you last held at?
Heathrow (13)

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	2 (15%)
17-21 years	1 (8%)	*50-59 years*	1 (8%)
22-29 years	5 (38%)	*60 years or older*	0 (0%)
30-39 years	4 (31%)		

Q4 Are you:

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

Q5 What is your ethnic origin?

White - British	2 (15%)
White - Irish	0 (0%)
White - other	3 (23%)
Black or black British - Caribbean	1 (8%)
Black or black British - African	3 (23%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	1 (8%)
Asian or Asian British - Pakistani	1 (8%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	1 (8%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (8%)

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

Yes	4 (36%)
No	7 (64%)

Q7 What, if any, is your religion?

None	1 (8%)
Church of England	2 (17%)
Catholic	4 (33%)
Protestant	0 (0%)

Other Christian denomination	0 (0%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	4 (33%)
Sikh	1 (8%)
Any other religion, please specify	0 (0%)

Q8 How would you describe your sexual orientation?

Straight/heterosexual	11 (100%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	0 (0%)

Q9 Do you consider yourself to have a disability?

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

Q10 Have you ever been held in police custody before?

Yes	10 (83%)
No	2 (17%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?

Less than 24 hours	9 (69%)
More than 24 hours, but less than 48 hours (2 days)	2 (15%)
More than 48 hours (2 days), but less than 72 hours (3 days)	2 (15%)
72 hours (3 days) or more	0 (0%)

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

Yes	9 (69%)
No	3 (23%)
Don't know/can't remember	1 (8%)

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

Yes	5 (38%)
No	6 (46%)
I don't know what this is/I don't remember	2 (15%)

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

My clothes were not taken	5 (42%)
I was offered a tracksuit to wear	2 (17%)
I was offered an evidence/paper suit to wear	1 (8%)
*I was **only** offered a blanket*	2 (17%)
Nothing	2 (17%)

Q15 Could you use a toilet when you needed to?

Yes	11 (85%)
No	2 (15%)
Don't know	0 (0%)

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

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

Q17 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	7 (64%)	1 (9%)	3 (27%)
Ventilation/air quality	5 (45%)	1 (9%)	5 (45%)
Temperature	4 (33%)	2 (17%)	6 (50%)
Lighting	10 (83%)	0 (0%)	2 (17%)

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

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

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

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

Q20 **Were you held overnight?**

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

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

Not held overnight	3 (23%)
Pillow	6 (46%)
Blanket	5 (38%)
Nothing	3 (23%)

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

Not held overnight/did not get any bedding	6 (55%)
Yes	3 (27%)
No	2 (18%)

Q23 **Were you offered a shower at the police station?**

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

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

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

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	10 (77%)	3 (23%)
Drink?	8 (62%)	5 (38%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	1 (8%)	4 (31%)	3 (23%)	4 (31%)	1 (8%)

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

I did not have any food or drink	1 (8%)
Yes	3 (23%)
No	9 (69%)

Q28 If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply to you.)

I do not smoke	5 (38%)
I was allowed to smoke	0 (0%)
I was offered a nicotine substitute	0 (0%)
I was not offered anything to cope with not smoking	8 (62%)

Q29 Were you offered anything to read?

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

Q30 Was someone informed of your arrest?

Yes	8 (62%)
No	3 (23%)
I don't know	1 (8%)
I didn't want to inform anyone	1 (8%)

Q31 Were you offered a free telephone call?

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

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

My telephone call was not denied	8 (67%)
Yes	0 (0%)
No	4 (33%)

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

	Yes	*No*
Who was taking care of your children	1 (14%)	6 (86%)
Contacting your partner, relative or friend	5 (50%)	5 (50%)
Contacting your employer	2 (25%)	6 (75%)
Where you were going once released	1 (13%)	7 (88%)

Q34 Were you offered free legal advice?

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

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	3 (23%)
Yes	8 (62%)
No	2 (15%)

Q36 Were you interviewed by police about your case?

Yes	8 (73%)
No	3 (27%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	3 (25%)
Yes	7 (58%)
No	2 (17%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	6 (55%)
Yes	2 (18%)
No	3 (27%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	5 (45%)
Yes	3 (27%)
No	3 (27%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	7 (64%)
No	4 (36%)

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

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

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

I have not been victimised	11 (85%)	*Because of your crime*	0 (0%)
Insulting remarks (about you, your family or friends)	1 (8%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	0 (0%)	*Because you have a disability*	0 (0%)
Sexual abuse	1 (8%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	1 (8%)
Drugs	0 (0%)		

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

Yes	5 (45%)
No	3 (27%)
I wasn't handcuffed	3 (27%)

Q45 Were you restrained while in the police custody suite?

Yes	2 (20%)
No	8 (80%)

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

Yes	4 (36%)
No	7 (64%)

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

Yes	2 (18%)
No	9 (82%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
1 (9%)	1 (9%)	7 (64%)	1 (9%)	1 (9%)	0 (0%)

Section 4: Health care

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

Yes	3 (27%)
No	6 (55%)
Don't know	2 (18%)

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

	Yes	*No*
Doctor	4 (36%)	7 (64%)
Nurse	0 (0%)	8 (100%)
Paramedic	0 (0%)	8 (100%)

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

Yes	1 (10%)
No	6 (60%)
Don't know	3 (30%)

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

Yes	3 (27%)
No	8 (73%)

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

Not taking medication	8 (73%)
Yes	3 (27%)
No	0 (0%)

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

Yes	1 (9%)
No	10 (91%)

Q56 **Did you see, or were you offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems	10 (91%)
Yes	0 (0%)
No	1 (9%)

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

I didn't have any drug/alcohol problems	10 (91%)
Yes	0 (0%)
No	1 (9%)

Q58 **Please rate the quality of your health care while in police custody:**

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
7 (64%)	2 (18%)	0 (0%)	1 (9%)	0 (0%)	1 (9%)

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

Yes	3 (30%)
No	7 (70%)

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

Yes	3 (27%)
No	8 (73%)

Q61 **If you had any mental health care needs, were you seen by a mental health nurse/psychiatrist?**

I didn't have any mental health care needs	8 (80%)
Yes	1 (10%)
No	1 (10%)

Prisoner survey responses for Heathrow Police 2011

Prisoner survey responses (missing data have been excluded for each question). Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

		Heathrow police 2011	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		13	1626
SECTION 1: General information			
3	Are you under 21 years of age?	**8%**	**9%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**62%**	**30%**
6	Are you a foreign national?	**36%**	**14%**
7	Are you Muslim?	**33%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**26%**	**20%**
10	Have you been in police custody before?	**83%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**30%**	**67%**
12	Were you told your rights when you first arrived?	**70%**	
13	Were you told about PACE?	**38%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**30%**	
15	Could you use a toilet when you needed to?	**84%**	**90%**
16	If you used the toilet, was toilet paper provided?	**38%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**64%**	**31%**
17b	Ventilation/air quality?	**45%**	**21%**
17c	Temperature?	**33%**	**15%**
17d	Lighting?	**83%**	**43%**
18	Was there any graffiti in your cell when you arrived?	**38%**	**55%**
19	Did staff explain the correct use of the cell bell?	**38%**	**22%**
20	Were you held overnight?	**77%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**69%**	
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**60%**	
23	Were you offered a shower?	**0%**	**9%**
24	Were you offered a period of outside exercise?	**0%**	**6%**
25a	Were you offered anything to eat?	**77%**	**81%**
25b	Were you offered anything to drink?	**62%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**9%**	**10%**
27	Was the food/drink you received suitable for your dietary requirements?	**26%**	**44%**

Key to tables

		Heathrow police 2011	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	0%	7%
29	Were you offered anything to read?	0%	13%
30	Was someone informed of your arrest?	62%	42%
31	Were you offered a free telephone call?	62%	49%
If you were denied a free telephone call:			
32	Was a reason given?	0%	14%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	15%	14%
33b	Contacting your partner, relative or friend?	50%	53%
33c	Contacting your employer?	26%	20%
33d	Where you were going once released?	13%	32%
34	Were you offered free legal advice?	77%	
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	80%	
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	77%	
38	Was an appropriate adult present when you were interviewed?	40%	
39	Was an interpreter present when you were interviewed?	50%	
SECTION 3: Safety			
41	Did you feel unsafe?	36%	39%
42	Has another detainee or a member of staff victimised you?	16%	
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	8%	
43b	Physical abuse (being hit, kicked or assaulted)	0%	
43c	Sexual abuse	8%	
43d	Your race or ethnic origin	0%	
43e	Drugs	0%	
43f	Because of your crime	0%	
43g	Because of your sexuality	0%	
43h	Because you have a disability	0%	
43i	Because of your religion/religious beliefs	0%	
43j	Because you are from a different part of the country than others	8%	
44	Were your handcuffs removed on arrival at the police station?	61%	75%
45	Were you restrained while in the police custody suite?	21%	18%
46	Were you injured while in police custody, in a way that was not your fault?	36%	24%
47	Were you told how to make a complaint about your treatment?	19%	13%
48	Were you treated well/very well by staff in the police custody suite?	19%	

Key to tables

		Heathrow police 2011	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**28%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**36%**	**47%**
51b	Nurse	**0%**	**20%**
	Percentage seen by either a doctor or a nurse	**36%**	**53%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**10%**	**27%**
53	Did you need to take any prescribed medication when you were in police custody?	**28%**	**45%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**100%**	**35%**
55	Did you have any drug or alcohol problems?	**9%**	**55%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**0%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**0%**	
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**50%**	**29%**
59	Did you have any specific physical health care needs?	**31%**	**33%**
60	Did you have any specific mental health care needs?	**28%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**50%**	