Report on an unannounced inspection visit to police custody suite in the Metropolitan Police Service Borough Operational Command Unit of Waltham Forest

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by

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Ashley House
Monck Street
London SW1P 2BQ
England

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1. Introduction

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.

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.

The inspection looked at the custody suite in Leyton, serving the London Borough of Waltham Forest within the Metropolitan Police Service (MPS). Strategic oversight of the suite was provided centrally by the MPS Criminal Justice Directorate within Territorial Policing, which seeks to ensure consistency in custody provision across all London boroughs. The Mayor's Office for Policing and Crime (MOPC) has responsibility for the estate and manages an active independent custody visitors scheme. At the time of the inspection, the borough was undertaking a pilot scheme, sharing its custody facilities with the neighbouring borough of Newham. This was a positive initiative but needed greater coordination.

Strategic oversight of custody was good but quality assurance procedures needed improvement. There was a dedicated custody manager for the BOCU managing permanent borough custody staff but different arrangements for the Newham Borough staff working at Leyton were causing confusion. There was an effective process for recording successful interventions ('near misses') but management oversight of these needed improvement. As we have found elsewhere, there was a lack of appropriate monitoring of the use of force.

Physical conditions at the suite were very good. Cells were clean, free from graffiti and cell inspections found no ligature points. Interactions with detainees were good but there was limited attention to diversity, in particular vulnerable adults, females and children. The quality of initial risk assessments was generally good but shift handover procedures needed attention. The booking-in arrangements at the custody desk had the potential to provide privacy but were not effectively utilised.

An appropriate balance was maintained between progressing cases and the rights of individuals, and the Police and Criminal Evidence Act (PACE) was rigorously adhered to. There was little focus on the necessity test or alternatives to dealing with offenders outside the custody environment. Juveniles and vulnerable adults were well served by an appropriate adult scheme but the lack of local authority PACE beds led to some juveniles being unnecessarily detained overnight. Arrangements for managing DNA and forensic samples were good but arrangements for taking complaints were poor.

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

Support and diversion arrangements for substance misuse were well developed. However, there was no mental health diversion or liaison service. Detainees presenting with mental health problems were referred to the local community mental health team. Custody was not used as a place of safety under the Mental Health Act.

Overall, custody provision in Waltham Forest was reasonably good. This report sets out a small number of recommendations that we hope will assist the MPS and MOPC to improve the delivery of custody in the BOCU further. We expect an action plan to be provided in due course.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

2012

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 borough operational command unit (BOCU) of Waltham Forest. We examined force-wide and BOCU custody strategies, as well as treatment and conditions, individual rights and health care in the custody suite. The custody suite, located in Leyton, had 30 cells and was open 24 hours a day. It had received 4,815 detainees between 1 July 2011 and 30 January 2012. In the same period, 109 immigration detainees had been held.

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

Strategy

2.4 The MPS Criminal Justice Directorate (CJD), within the Territorial Policing Directorate, had strategic oversight of custody in all commands in London. The Mayor's Office for London had responsibility for the custody estate, although structures were not yet clear. The independent custody visitors (ICV) scheme was active and the borough was responsive to it.

2.5 Strategic oversight of custody within the BOCU was good, although some quality assurance mechanisms needed to be improved. The BOCU was engaged in a pilot to share the facilities at Leyton with those in the BOCU of Newham but difficulties were being experienced. Waltham Forest custody staff were permanent but Newham staff were on six-month placements in custody. All staff working in Waltham Forest had been trained. Partnership arrangements were well developed.

[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 Staff interactions with detainees were good. Awareness of diversity issues was mixed. Detainees were routinely asked if they had any dependency obligations.

2.7 Risk assessments were carried out when detainees arrived in custody and the quality of these was generally good, and risk management appropriate. Pre-release risk assessments were completed but the quality was mixed. Person escort records (PERs) lacked detail. Handovers between shifts took place but were inadequate.

2.8 The physical conditions were good. Detainees were provided with mattresses, pillows and blankets. Showers were rarely facilitated. Elements of detainee care were too reliant on them making requests.

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. Detainees were offered a copy of PACE. The management of DNA and forensics was adequate.

2.10 Legal assistance was offered. Children were not held in custody under section 46 of the Children Act 1989.[3] Immigration detainees were moved on from police custody relatively quickly. Professional interpreting services were generally used when needed, although not in all cases.

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 alternative.

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

Health care

2.13 Primary health services and clinical governance were good.

2.14 Medicines management arrangements and medical rooms were good. Detainees could continue to take prescribed medication while in custody. Resuscitation equipment was available to custody staff, who were trained in its use. Substance misuse services were well developed.

2.15 There was no mental health diversion or liaison service. Detainees presenting with mental health problems were referred to the local community mental health team and staff reported some delays. There were problems getting assessments for Newham residents. Custody was not used as a place of safety under the Mental Health Act.

[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.

Main recommendation

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

National issues

2.17 Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours.[4]

[4] 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.

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 CJD, led by a commander within Territorial Policing Headquarters. A superintendent was responsible for the day-to-day management of the CJD. Responsibility for day-to-day management of Waltham Forest's custody suite and delivery of services had been devolved to the BOCU, and accountability therefore rested with the BOCU commander. The Mayor's Office for Policing and Crime (MOPC) had recently taken over from the Metropolitan Police Authority (MPA) but there was no MOPC lead for custody.

3.2 The CJD had an inspection function for audit and compliance, health and safety and the implementation of Safer Detention and Handling of Persons in Police Custody 2011 (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 BOCU. 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. They were designed to assist BOCUs to deliver consistent levels of service.

3.4 Strategic leadership for the custody function was provided by the BOCU detective superintendent. At the senior management team (SMT) level, there was a higher executive officer (HEO) integrated prosecution team (IPT) lead, who line-managed a dedicated custody manager, who was an inspector. There was good visibility of the SMT in custody.

3.5 A full-time inspector undertook the custody manager function, supported by two part-time sergeants, a constable and a drug intervention programme (DIP) worker. The custody manager line-managed the Waltham Forest custody sergeants.

3.6 The CJD had facilitated an organisational self-assessed risk register for all MPS custody suites. The BOCU commander had ownership of the risks and had introduced measures to mitigate them. Most of these measures had been put into practice, and the register was up to date. On a day-to-day basis, this was managed by the custody manager and monitored by the HEO IPT lead, with an escalation process to the SMT.

3.7 Bail management was an agenda item at the daily management meeting, with successful interventions and constant watches raised by exception. Custody issues were raised by exception at a weekly SMT meeting, which was attended by the HEO, and there was informal weekly liaison between the HEO and the custody manager. Custody health and safety issues were discussed at the BOCU health and safety meeting. There was no custody user meeting, and therefore no forum for practitioners to discuss issues.

3.8 At the time of the inspection, the custody suite was undertaking a pilot scheme with the Borough of Newham. This pilot was led by the MPS Territorial Policing team. During this pilot, staff from the two boroughs worked alongside each other within the Waltham Forest custody suite, providing handling services for all Waltham Forest detainees and all volume crime detainees for Newham. We were told that cells often had to be closed and detainees diverted to the Borough of Redbridge. There was some confusion about the ownership of the pilot, and coordination needed to be improved. The pilot was suspended during the inspection to give time for these issues to be resolved.

3.9 Staffing levels in the custody suite were adequate and comprised permanent sergeants from the Borough of Waltham Forest, working a 12-hour shift pattern, carrying out custody sergeant duties. The custody sergeants were supported by permanent designated detention officers (DDOs), who looked after the ongoing care and welfare of detainees. The Newham sergeants were posted to the suite on a six-month rotational basis and were line-managed by the custody inspector from their borough. They worked a mixture of eight-, nine- and 10-hour shifts. These arrangements were confusing for staff, who were often unsure of which staff members were coming on duty or when. These arrangements presented risks during shift handovers, with the potential for information to be missed due to staff going off and coming on duty at differing times. Resilience within the staffing of custody units was provided by sergeants from the operational teams for custody sergeants and police constable (PC) gaolers for DDOs.

3.10 There was evidence of some ad-hoc dip-sampling of custody records taking place. However, there was no structured and auditable process for dip-sampling or wider quality assurance processes. This weakness was a risk to the BOCU, particularly as quality assurance and dip-sampling were repeatedly referenced within the MPS CJD risk register. The dip-sampling that was taking place did not include PERs or looking at CCTV coverage. (See also paragraph 4.21 concerning the use of handcuffs).

3.11 There were processes for dealing with successful interventions. A form was generated from the computer system in custody and passed on to the CJD. However, the BOCU SMT was not always sighted on the submission of these forms. 'Learning the lessons' information was input onto the CJD area on the force intranet, with an expectation from management that staff would regularly visit the site to update themselves. However there was no custody-specific link on the BOCU intranet pages and some staff were unclear about what information they would receive and how to access it.

Recommendation

3.12 Key outcomes for detainees described in custody records and person escort records should be quality assured, through dip-sampling (which includes a scrutiny of the use of handcuffs). The dip-sampling should include periodic review of CCTV coverage and have a clear audit trail.

Housekeeping point

3.13 'Learning the lessons' briefings should be made available in an easily accessible section of the intranet.

Partnerships

3.14 Partnership arrangements were described as good, with the BOCU commander chairing the Local Strategic Partnership Group and the Local Crime Reduction Partnership. The BOCU was also represented at SMT level at various subgroups, such as the Children's Safeguarding Executive Board, Crown Prosecution Service (CPS) and Court User Group meetings.

3.15 There was an established ICV scheme. ICVs told us that they were admitted to custody centres quickly and that staff were courteous and professional. There was regular police attendance at the ICV quarterly review meetings.

Learning and development

3.16 All DDOs and sergeants performing custody duties had received training before working in custody. Yearly mandatory training was provided, and custody refresher training had recently been reintroduced. DDOs had been trained to book in detainees, although it was not always clear which sergeant in the suite was specifically responsible for managing individual detainees.

4. Treatment and conditions

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

Respect

4.1 All custody staff interacted with detainees in a professional manner, which was respectful and friendly. Detainees told us that staff had treated them well throughout their time in the custody suite.

4.2 The booking-in area was spacious and the desks were at a reasonable height, with physical barriers between them. However, they offered limited privacy, as conversations could still be overheard. An additional, lower-level booking-in desk, offering a greater degree of privacy, was available. This was used for processing vulnerable detainees when sensitive issues needed to be discussed and also detainees using a wheelchair. At busy times, the booking-in area was crowded with non-custody staff; this contributed to a chaotic atmosphere.

4.3 Detainees were searched respectfully but this was not always carried out thoroughly. We saw escort staff recovering a large quantity of cash from a male juvenile, as his jacket was searched again before being taken to court.

4.4 Staff demonstrated a limited awareness of diversity, with a 'one size fits all' approach to booking in detainees that appeared to result in the particular needs of women, juveniles and members of minority ethnic groups being overlooked. None of the cells in the suite were designated for the sole use of women or juveniles, although staff indicated that they tried to use the cells nearest the booking-in area for this purpose but that this was not always possible. Female detainees were given the opportunity to speak to a female officer. All detainees were asked about dependency issues during the booking-in process. Staff had little awareness of safeguarding issues that could impact on juveniles or vulnerable adults. They were unsure where to refer such individuals if they identified any concerns.

4.5 There were prayer mats, a Qur'an and several Bibles available, although they were stored disrespectfully. The direction of Mecca was not indicated in any of the cells; a compass was available for this purpose but not all staff were aware of its existence.

4.6 The bed plinths in the cells were low, which made them unsuitable for some older detainees and those with disabilities, although staff told us that they provided additional mattresses for such detainees, to build up the height of the plinth. Several cells had wheelchair access and low-level call buttons adjacent to the bed plinths. A hearing loop was available in the booking-in area but we found only one member of custody staff who knew how to operate this.

Recommendations

4.7 Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women.

4.8 Staff should receive up-to-date training on child protection and safeguarding in respect of juveniles and vulnerable adults.

Housekeeping points

4.9 Personal searches of detainees should be thorough, to prevent the concealment of items.

4.10 Items used for religious observance should be stored respectfully.

4.11 All custody staff should be made aware of how to operate the hearing loop.

Safety

4.12 DDOs carried out the initial risk assessment, overseen by a custody sergeant, who decided on observation levels. Our custody record analysis showed that initial risk assessments were reasonably comprehensive and contained helpful information which was used to inform care plans. The national strategy for police information systems (NSPIS) custody system had an automatic prompt for officers to check the Police National Computer (PNC) about previously identified risks. In one case, a history of depression and drug abuse had been flagged from the PNC and appropriately considered in the detainee's risk assessment, despite the detainee denying his history.

4.13 We examined 12 PERs relating to detainees for whom concerns about self-harm arising from risk assessments had been identified. These revealed a reasonable level of concordance with custody records but some lacked all the relevant information.

4.14 Our custody record analysis showed that risk assessments were reviewed and amended appropriately during a detainee's stay. DDOs understood the type of response they should obtain when conducting rousing checks.

4.15 All cells and communal areas in the custody suite were monitored by CCTV, which included an audio capability. Cells were checked after each occupation to identify if any unauthorised items had been left behind. All custody staff carried anti-ligature knives.

4.16 Shift patterns allowed no time for effective staff handovers but staff arrived early for their shift to enable this to happen. There were separate staff handovers for custody sergeants and DDOs, which could have resulted in essential information about risk not being passed on. In the case of DDOs, we witnessed a handover taking place before all the relieving shift had arrived. In several cases, the custody record analysis revealed gaps in observation checks recorded in detention logs during periods of staff handover, making it unclear whether the checks had taken place. Individual preference dictated whether custody sergeants held an additional handover with their own team.

4.17 The custody record system incorporated a pre-release risk assessment prompt. The quality of pre-release risk assessments was variable. Our examination of custody records revealed that in three cases out of 30, no pre-release risk assessment had been completed. In a further three cases involving detainees who had been in custody for domestic violence offences, officers had checked the detainees' living arrangements and ensured that they would not contact their victims on release. However, in one case involving a 51-year-old female detainee, the pre-release risk assessment showed no consideration of how she would get home, even though she had been released late at night. Vulnerable detainees were given a comprehensive leaflet detailing a list of support agencies when they left the custody suite but this was available only in English.

Recommendations

4.18 Handovers should be comprehensive and attended by detention officers and police custody staff.

4.19 Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to ameliorate them when needed.

Housekeeping point

4.20 Pre-release leaflets should be available in a range of languages.

Use of force

4.21 In our prisoner survey, only 54% of respondents said that their handcuffs had been removed on arrival at the custody suite, against the comparator of 73%, and 41% that they had been restrained while in the police custody suite, against the comparator of 18%. Almost all detainees we observed arriving at the custody suite in handcuffs were released from them promptly; however, staff reported differing views as to whether arresting officers or custody sergeants should determine when handcuffs should be removed (see recommendation 3.12).

4.22 Custody staff recorded the use of force on custody records but such data were not collated at a local or force-wide level. We were told that if force was used in the custody area, a detainee was normally seen by a health care professional shortly afterwards. All staff had been trained in approved safety techniques and received annual refresher training.

4.23 Staff told us that the need to strip-search a detainee formed part of the risk assessment process. Data supplied by the force showed that between 1 July 2011 and 30 January 2012, 450 detainees had been strip-searched in the BOCU. The frequency of strip-searching did not give us any cause for concern.

Recommendation

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

Physical conditions

4.25 The cells were clean, bright, free of graffiti and well decorated, with no evident ligature points. Arrangements for cleaning and routine maintenance worked well, although there was an ongoing issue of cells being taken out of use when low external temperatures were recorded. During the inspection, one wing, comprising 13 cells, was out of use due to the lack of heating. The contractors who had constructed the building had been requested to investigate this issue. Toilets, washbasins, showers and booking-in areas were clean and tidy.

4.26 Despite the custody suite being a relatively new building, there were major maintenance issues. We saw panic alarms being activated twice, with no evident reason for the activations. Staff told us that these 'phantom' activations were a regular occurrence, which, despite the fault being reported, continued to recur. Staff were slow to respond to the panic alarms as they

were never sure if the activation was genuine. We also found that one of the gates in the vehicle lock was faulty and, according to staff, had been so for some time, leading to security concerns.

4.27 There was a system of daily cell checks, carried out by DDOs and signed off by the custody sergeant, although there were some gaps in the process where daily checks had not been recorded. Weekly checks were undertaken by members of the SMT, although, again, there were similar gaps in this process. It was unclear what monthly checks were taking place, although a recent health and safety inspection had been undertaken. Staff reported prompt action to rectify issues identified, usually within 24 hours.

4.28 Entry to the cells was controlled electronically through the swipe of a staff member's warrant card, followed by the keying in of their individual PIN code. As keys were not required, it was possible for non-custody staff to remove a detainee from a cell without the knowledge of custody staff. We saw a custody sergeant checking detainees in their cells following a handover, at which point it was discovered that one detainee was missing. None of the staff on duty had knowledge of the individual's whereabouts; he was located subsequently in interview with detectives.

4.29 Cell call bells operated through an intercom system, which was also available for putting telephone calls through to detainees in their cells; the use of this was explained to detainees when they were located in the cell. We saw staff responding promptly to cell call bells, and this was confirmed by detainees we spoke to.

4.30 There was a fire evacuation policy, which was displayed in the booking-in area, but it lacked detail and staff were unsure of the location of the rendezvous point. A few staff could recall a fire evacuation drill taking place shortly after the building opened in October 2010 but most had never experienced a drill or evacuation. The suite was equipped with sufficient sets of rigid handcuffs and other evacuation equipment. These were stored in two large kitbags at the rear of the booking-in area but it was evident that the contents of these bags had not been checked for some time and were showing signs of wear. Smoking was not allowed in the custody suite or exercise area.

Recommendations

4.31 Regular maintenance inspection checks of the facilities should be carried out, including quarterly and annual checks, and major issues impacting on staff safety and security concerns should be addressed at the earliest opportunity.

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

Housekeeping point

4.33 Regular fire evacuation drills should be carried out and recorded, and regular checks of the fire evacuation kitbags should be made, to ensure that the contents are properly maintained and fit for use.

Detainee care

4.34 All cells contained a mattress and a pillow but they were not routinely wiped down between uses. We found stocks of clean blankets but staff told us that they supplied these only on request. In our survey, only 62% of respondents, against the 86% comparator, said that they had been given any items of bedding, of whom 78%, against the 55% comparator, said that these had been clean. All cells had toilets and hand-washing facilities but toilet paper was available only on request. The toilet area was obscured on the CCTV images of the cells.

4.35 In our survey, none of the respondents said that they had been offered a shower, and this was borne out in our custody record analysis which showed that only one detainee out of 30 records reviewed had been offered, and taken, a shower. Our analysis also showed that one detainee had had his request to wash before going to court granted. The showers on the cell corridors were private but only paper towels were available.

4.36 Hygiene items such as toothpaste and razors were available but female detainees were not routinely offered a hygiene pack.

4.37 There were stocks of replacement clothing, including paper suits, tracksuits, plimsolls and underwear for females. Staff told us that, in the first instance, they encouraged family and friends to bring in replacement clothing when needed but unless detainees were being released or transferred to court, they provided a paper suit.

4.38 There was a good stock of microwave meals, including halal and vegetarian options. These were issued at recognised mealtimes and when requested. We observed drinks being offered regularly but only 66% of respondents to our survey, against the comparator of 83%, said that they had been offered a drink. In the 30 custody records we looked, only 17 detainees (57%) had been offered at least one meal while in custody.

4.39 Although the custody suite had an exercise yard, detainees were rarely, if ever, offered exercise. The yard had two panic alarms fitted but no call bell, which necessitated staff having constantly to supervise any detainee who used the facility; we were told that staff rarely had time to do this. In our custody record analysis, no detainees in the sample had been offered outside exercise.

4.40 The custody suite contained a limited range of books and newspapers, which members of staff had supplied. There was nothing available in foreign languages, in easy-read format or suitable for juveniles. In our custody record analysis, one detainee had been provided with reading materials. Visits to detainees from family members were not encouraged due to the lack of visiting facilities. Staff told us that on rare occasions a juvenile would be allowed a visit, but only if their parent or a family member acted as an AA.

Recommendations

4.41 All detainees held overnight, or who require one, should be offered a shower and be provided with a fabric towel.

4.42 Appropriate replacement clothing rather than paper suits should be given to detainees to wear when their clothes are removed.

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

4.44 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods.

Housekeeping points

4.45 Blankets should be provided routinely and mattresses should always be wiped down between uses.

4.46 Toilet paper should be routinely provided in each cell and hygiene packs should be routinely offered to female detainees.

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

5. Individual rights

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

Rights relating to detention

5.1 We observed custody sergeants checking the circumstances of the offence and arrest to determine if detention was appropriate. However, most custody sergeants had little focus on the necessity test and could recall only a few occasions when they had refused to detain. The case progression unit (CPU) terminated duty at 10pm and staff told us that it was unusual for detectives to deal with detainees during the night. This led to detainees being 'bedded down' for the night. In our survey, 100% of detainees, against a comparator of 92%, said that they had been held overnight. In our analysis of 30 custody records, 14 detainees had been held overnight, including those who had arrived between midnight and 3am. One detainee had been held for more than 24 hours.

5.2 We were told that there was a good relationship with UK Border Agency staff but that some immigration detainees waited several days to be collected; however, custody staff believed that detention times had improved recently. Data supplied by the force showed that in the previous six months, 109 immigration detainees had been held in the custody suite, with the average detention time being just under 18 hours.

5.3 Staff provided all detainees with a leaflet summarising their rights and entitlements, which was available in a range of languages but had not been adapted for detainees with learning difficulties or limited literacy. A professional telephone interpreting service, used with two-handset telephones, was readily available at both the booking-in desks and in the health care room. A face-to-face interpreting service was also available to facilitate investigative interviews. Our custody record analysis showed that in three of the six cases where an interpreter had attended, the interpreter had been present for both the reading of rights and the interview; in two cases the interpreter had been present for the interview only and in the third case the detainee's solicitor had cancelled their consultation because of the need for interpreting services. In these cases, it was unclear how risk assessments had been completed or if the telephone interpreting service had been utilised.

5.4 Staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989. Staff said that they contacted Social Services to confirm the availability of secure PACE beds for juveniles held overnight who could not be bailed; however, none were aware of any such beds ever having been made available.

5.5 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 they were otherwise deemed vulnerable (see recommendation 2.17). Family members or family friends were usually contacted in the first instance to act as an AA. When this was not possible, an effective, 24-hour service was provided by a private contractor, catering for both juveniles and vulnerable adults. Staff did not report any delays in AAs attending the custody suite. However, staff were unclear whether this service was available for detainees from Newham, who could also be housed in the custody suite.

5.6 In our custody record analysis, four (13%) detainees had mental health problems. None of these had had an AA present when their rights were explained to them or during interviews. For one of the detainees in the sample under 17 years of age, it had been noted during the reading of rights and a subsequent inspector review that an AA was required but there was no evidence that one had attended.

Recommendations

5.7 The MPS should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged to appear in court but cannot be bailed.

5.8 Appropriate adults should be available to support without undue delay vulnerable adults in custody, including out of hours.

Housekeeping point

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

Rights relating to PACE

5.10 Custody record analysis indicated that all detainees were offered legal representation; 14 detainees (47%) had declined this offer, with a reason for this being recorded in only two of these cases. Eleven of these 14 detainees had been held for over six hours but only six had been reminded of their right to free legal advice. In the latter cases, we found that the inspector reviews had been carried out in the detainee's absence. A duty solicitor scheme was in place. Posters advertising this, in 11 different languages, were displayed prominently in the custody suite. In our survey, all respondents said that they had been offered free legal advice.

5.11 The custody suite had five clean, well-equipped interview rooms.

5.12 During the booking-in process, detainees were told that they could read the PACE codes of practice. In our survey, only 32% of respondents, against the 52% comparator, said that they had been told about PACE.

5.13 Detainees were told that they could have someone informed of their whereabouts. However, in our custody record analysis, in only three of the eight cases (27%) where the detainee had asked for someone to be informed of their arrest was there evidence of an attempt to contact the nominated person. In another case there was no explanation as to why the nominated person had not been contacted but the detainee had been allowed to make a telephone call approximately five hours later.

5.14 Reviews of detainees in custody were mostly undertaken by a police inspector who had specific PACE responsibilities; however, during the night this role was covered by the duty inspector. Our observations and analysis of custody records confirmed that most reviews took place face to face and on time. However, in eight cases in our custody record sample, inspectors had conducted reviews while the detainee had been asleep or in interview, and there was no evidence that these detainees had later been informed of these reviews. In three cases the reviews had been conducted over the telephone and this had been recorded in the detention log.

5.15 There was an effective process for the prompt collection of DNA samples. However, forensic samples were stored together with DNA samples, which could have led to the loss or misplacing of samples.

5.16 Arrangements for getting detainees to court on time were efficient. Court cut-off times were reasonable, being approximately 2pm on weekdays, with some flexibility, and 8am on Saturdays. We witnessed the court agreeing to accept a detainee who had been transported from the custody suite at 1.50pm. A video-link for court purposes had been installed but was not in use.

Housekeeping points

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

5.18 The force should keep DNA samples separate from other samples.

Rights relating to treatment

5.19 When detainees arrived in custody, they were not routinely told how to make a complaint about their treatment and there were no notices about the complaints procedure on display in the custody suite.

5.20 Although there was a clear expectation from the BOCU that complaints from detainees would be taken by the PACE inspector while the detainee was still in custody, practices varied among staff members. Some DDOs indicated that they would advise the custody sergeant if an individual wished to complain; however, most said that they would send such detainees to the front desk on release. A limited analysis of complaints was undertaken.

Recommendation

5.21 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 data about complaints should be monitored.

6. Health care

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

Governance

6.1 Primary health services were provided by the MPS CJD within the Territorial Policing Directorate. There were nurses based in the suite 24 hours a day. Substance misuse services were provided by the Westminster Drug Project on behalf of the local DIP, and mental health services by the North East London Mental Health Foundation Trust (NELFT).

6.2 Nurses we spoke to had been working in the suite since October 2011 and had received a comprehensive induction and attended regular training events. They were clear about whom they could approach for advice and had a good understanding of clinical policies and procedures, all of which were accessible on the local intranet.

6.3 The main clinical room was close to the booking-in desks. It was fit for purpose, although sharps bins had not been signed or dated on assembly. The room had a two-handset telephone for use when interpreting services were required. There was a second clinical room sited away from the custody desk which was cold and rarely used.

6.4 Resuscitation equipment was available in sealed bags behind the custody desk and at strategic points around the suite; staff knew where these were kept. Equipment included a defibrillator, which was supposed to be checked daily, although we found that in the previous 15 days it had been checked only five times. Staff told us that custody sergeants received cardiopulmonary resuscitation (CPR) training/updates annually and that DDOs received CPR training twice yearly.

Patient care

6.5 In our survey, 32% of detainees, against the 52% comparator, said that they had seen a nurse or a doctor while in custody, of whom 40% rated the quality of care as good or very good. In our review of custody records, seven (23%) detainees had been seen by a nurse or the FME. The longest wait had been approximately four hours 19 minutes, although the average was approximately 42 minutes. In one instance, the fact that a detainee was diabetic had been flagged in the risk assessment and he had been due to take medication on the following morning; health care professionals had not been called until 2pm the following day. One detainee had requested to see a health care professional but this had not happened. There was little explanation of why this had been the case, and he had been held for a further four to five hours following this request.

6.6 Nurses worked 12-hour shifts, and handovers between staff were comprehensive and provided both verbally and via a secure email, which was copied to their line manager. Nurses sometimes observed detainees being booked in, as this helped them to assess the detainee and reduced the need to repeat some questions if they subsequently were called to treat them.

6.7 Nurses used proformas to record their interactions with detainees. These were stored in a locked drawer but were available for reference if the detainee was seen by more than one

nurse during their time at the suite. The records we looked at were comprehensive, with evidence of staff seeking information from other sources in order to provide the detainee with suitable care and information. Nurses entered relevant information onto NSPIS (National Strategy for Police Information Systems). The proforma then required the custody sergeant to sign to say that he or she had received and understood the information provided but did not require detainees to sign to consent for information to be shared; only verbal consent was required. However, this was mitigated by the need for the detainee to sign a letter which was faxed to other health professionals in the community if collateral information was requested.

6.8 We did not see any FMEs at Leyton custody suite but nurses told us that they did not use the proformas and that some still used the old medical record forms (Book 83). It was not clear how or where they stored their records in confidence with Caldicott principles.[5]

6.9 Medicines were stored in a locked cupboard behind the custody desk. This cupboard was monitored by CCTV but was located on the opposite side of the suite to the clinical room; access was limited to nursing staff. Records were kept of the use of diazepam and dihydrocodeine tablets, which were correct when we checked them. Nurses administered all medications; they had patient group directions for some conditions/medications. Medications were usually not provided unless the detainee had been in custody for six hours; while we understood the reasons for this rule, we were concerned that it was too stringent, given that there was evidence of long waits to be booked into custody following arrest, which would have delayed the administration of medications beyond six hours.

6.10 Custody staff made attempts to retrieve prescribed medications from a detainee's home where possible and there was evidence of this in our custody record analysis; nurses told us that as long as the medication was in its original packaging, correctly labelled and less than three months old, they would contact an FME to prescribe it on NSPIS and then administer it. However, it was rare for a detainee to receive methadone or any other previously prescribed substitute medications for substance addiction while in custody; instead, they were prescribed dihydrocodeine tablets.

Recommendations

6.11 The MPS should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott principles.

6.12 Detainees should receive prescribed medication to meet any clinical signs, symptoms or conditions.

Substance use

6.13 In our survey, 59% of respondents said that they had had a substance misuse issue on arrest, of whom 43% had seen a drug worker while in custody. Drug workers provided cover in the suite from 7am until 10pm during the week and from noon until 7.30pm at weekends. While they primarily saw detainees who tested positive to class A substances, they also provided a service to anyone over 18 with any drug or alcohol issues and signposted juveniles to appropriate services. They provided harm minimisation information as well as referral follow-up appointments.

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

6.14 Information obtained from the team indicated that the average positive rate (requiring assessment by the DIP) was about 40 per month from 150–200 Cozart tests[6] for trigger offences. About half of these were for Waltham Forest residents.

6.15 There was no needle exchange programme available in custody, although there were local pharmacies that had such a service.

Housekeeping point

6.16 Detainees being released in to the community should be given clean injecting equipment if required.

Mental health

6.17 There was no mental health liaison or diversion team available in custody. If detainees presented with mental health issues, the FME referred them to the local community mental health team and there was an information-sharing protocol with NELFT. Staff reported some delays in referrals, especially out of hours. The recent arrangements for Newham BOCU to share the custody suites had resulted in some problems in getting mental health assessments if the detainee was a Newham resident, as this area was covered by another mental health trust and health staff from this trust were reluctant to attend the suite. In our survey, 32% of respondents said that they had specific mental health needs but none had been seen by a mental health professional (see main recommendation 2.16).

6.18 Custody staff had not received recent mental health awareness training. Some told us that they would welcome training, to improve their confidence in dealing with detainees with such issues.

6.19 We were told that the custody suite was not used as a place of safety for section 136 detainees, and data from the MPS CJD supported this. There was a dedicated section 136 suite for the borough at the local mental health hospital, which was part of NELFT. The unit was not staffed unless occupied by a patient. There was an inter-agency procedure for the management of people detained under section 136 to which the police had contributed; it was being updated at the time of the inspection. There were bimonthly section 136 liaison meetings, chaired by NELFT and attended by the BOCU's liaison officer, at which all section 136 admissions were discussed.

6.20 Management data on the use of the section 136 suite was kept by NELFT. Data showed that about 100 detainees per year were taken to the suite from Waltham Forest, and that just over 50% of people were later admitted as either formal or informal patients. Staff told us that most people brought in under section 136 were appropriate for the mental health service, as most of those discharged were later followed in the community as outpatients. NELFT staff commented that the police had occasionally taken patients to the unit who were not detained under section 136 or were without any documentation and that staff had refused to admit them. This was attributed to a lack of training and experience of officers and the issue was being addressed through the police liaison meetings.

[6] The Cozart(R) RapiScan oral fluid drug testing system is used in a number of police custody suites across England and Wales. The programme is designed to identify detainees using the Class A drugs, heroin, cocaine and crack cocaine, and to refer them for treatment.

Recommendation

6.21 Information-sharing protocols and arrangements for mental health assessments should be in place with all local mental health trusts, to ensure that detainees receive prompt assessment and treatment.

7. Summary of recommendations

Main recommendation

7.1 There should be a liaison and/or diversion scheme that enables detainees with mental health problems to be identified and diverted to appropriate mental health services. (2.16)

National issues

7.2 Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours. (2.17)

Recommendations

Strategy

7.3 Key outcomes for detainees described in custody records and person escort records should be quality assured, through dip-sampling (which includes a scrutiny of the use of handcuffs). The dip-sampling should include periodic review of CCTV coverage and have a clear audit trail. (3.12)

Treatment and conditions

7.4 Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women. (4.7)

7.5 Staff should receive up-to-date training on child protection and safeguarding in respect of juveniles and vulnerable adults. (4.8)

7.6 Handovers should be comprehensive and attended by detention officers and police custody staff. (4.18)

7.7 Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to ameliorate them when needed. (4.19)

7.8 The Metropolitan Police Service (MPS) should collate use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.24)

7.9 Regular maintenance inspection checks of the facilities should be carried out, including quarterly and annual checks, and major issues impacting on staff safety and security concerns should be addressed at the earliest opportunity. (4.31)

7.10 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.32)

7.11 All detainees held overnight, or who require one, should be offered a shower and be provided with a fabric towel. (4.41)

7.12 Appropriate replacement clothing rather than paper suits should be given to detainees to wear when their clothes are removed. (4.42)

7.13 Detainees held for long periods should be offered outside exercise. (4.43)

7.14 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods. (4.44)

Individual rights

7.15 The MPS should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged to appear in court but cannot be bailed. (5.7)

7.16 Appropriate adults should be available to support without undue delay vulnerable adults in custody, including out of hours. (5.8)

7.17 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 data about complaints should be monitored. (5.21)

Health care

7.18 The MPS should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott principles. (6.11)

7.19 Detainees should receive prescribed medication to meet any clinical signs, symptoms or conditions. (6.12)

7.20 Information-sharing protocols and arrangements for mental health assessments should be in place with all local mental health trusts, to ensure that detainees receive prompt assessment and treatment. (6.21)

Housekeeping points

Strategy

7.21 'Learning the lessons' briefings should be made available in an easily accessible section of the intranet. (3.13)

Treatment and conditions

7.22 Personal searches of detainees should be thorough, to prevent the concealment of items. (4.9)

7.23 Items used for religious observance should be stored respectfully. (4.10)

7.24 All custody staff should be made aware of how to operate the hearing loop. (4.11)

7.25 Pre-release leaflets should be available in a range of languages. (4.20)

7.26 Regular fire evacuation drills should be carried out and recorded, and regular checks of the fire evacuation kitbags should be made, to ensure that the contents are properly maintained and fit for use. (4.33)

7.27 Blankets should be provided routinely and mattresses should always be wiped down between uses. (4.45)

7.28 Toilet paper should be routinely provided in each cell and hygiene packs should be routinely offered to female detainees. (4.46)

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

Individual rights

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

7.31 Detainees should be informed of any reviews carried out while they were sleeping, and a record to this effect should be made in the custody record. (5.17)

7.32 The force should keep DNA samples separate from other samples. (5.18)

Health care

7.33 Detainees being released in to the community should be given clean injecting equipment if required. (6.16)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Peter Dunn	HMIP inspector
Fiona Shearlaw	HMIP inspector
Vinnett Pearcy	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Roger James	CQC inspector
Michael Skidmore	HMIP researcher
Hayley Cripps	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Waltham Forest, 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 23 January 2012. A list of potential respondents to have passed through Waltham Forest police station was created, listing all those who had arrived from Waltham Forest Magistrates' court within the previous two months.

Selecting the sample

Due to insufficient numbers in the prison from this area, 26 respondents were approached. Three respondents reported being held in police stations outside of Waltham Forest and two could speak no English and so it was not possible to determine the police station they had been held in. On the day, the questionnaire was offered to 21 respondents; four questionnaires were not returned. All of those sampled had been in custody within the previous two months.

Completion of the questionnaire was voluntary. Interviews were offered to 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, 17 (81%) respondents completed and returned their questionnaires.

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 50 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?

Waltham Forest, Leyton

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	1 (6%)
17-21 years	0 (0%)	*50-59 years*	0 (0%)
22-29 years	11 (65%)	*60 years or older*	0 (0%)
30-39 years	5 (29%)		

Q4 Are you:

Male	17 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	4 (24%)
White - Irish	1 (6%)
White - other	4 (24%)
Black or black British - Caribbean	1 (6%)
Black or black British - African	3 (18%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	3 (18%)
Mixed heritage - white and black Caribbean	1 (6%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	7 (47%)
No	8 (53%)

Q7 What, if any, is your religion?

None	3 (19%)
Church of England	4 (25%)
Catholic	5 (31%)
Protestant	0 (0%)
Other Christian denomination	1 (6%)
Buddhist	0 (0%)
Hindu	3 (19%)
Jewish	0 (0%)

Muslim 0 (0%)
Sikh 0 (0%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 15 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q9 Do you consider yourself to have a disability?
Yes 5 (29%)
No 12 (71%)

Q10 Have you ever been held in police custody before?
Yes 14 (88%)
No 2 (13%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 5 (29%)
More than 24 hours, but less than 48 hours (2 days) 4 (24%)
More than 48 hours (2 days), but less than 72 hours (3 days) 5 (29%)
72 hours (3 days) or more 3 (18%)

Q12 Were you told your rights when you first arrived there?
Yes 12 (71%)
No 3 (18%)
Don't know/Can't remember 2 (12%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 5 (31%)
No 8 (50%)
I don't know what this is/I don't remember 3 (19%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 8 (47%)
I was offered a tracksuit to wear 2 (12%)
I was offered an evidence/ paper suit to wear 5 (29%)
*I was **only** offered a blanket* 0 (0%)
Nothing 2 (12%)

Q15 Could you use a toilet when you needed to?
Yes 16 (100%)
No 0 (0%)
Don't know 0 (0%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 6 (35%)
No 11 (65%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	6 (35%)	8 (47%)	3 (18%)
Ventilation/air quality	5 (33%)	7 (47%)	3 (20%)
Temperature	4 (27%)	6 (40%)	5 (33%)
Lighting	11 (73%)	2 (13%)	2 (13%)

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

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

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

Yes 4 (27%)
No 11 (73%)

Q20 Were you held overnight?

Yes 17 (100%)
No 0 (0%)

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

Not held overnight 0 (0%)
Pillow 6 (38%)
Blanket 8 (50%)
Nothing 6 (38%)

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

Not held overnight/did not get any bedding 6 (40%)
Yes 7 (47%)
No 2 (13%)

Q23 Were you offered a shower at the police station?

Yes 0 (0%)
No 16 (100%)

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

Yes 1 (6%)
No 15 (94%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	12 (75%)	4 (25%)
Drink?	10 (67%)	5 (33%)

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

Very good	*Good*	*Neither*	*Bad*	*Very Bad*	*N/A*
0 (0%)	4 (29%)	5 (36%)	1 (7%)	4 (29%)	0 (0%)

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

I did not have any food or drink 0 (0%)
Yes 4 (27%)

No 11 (73%)

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 4 (24%)
I was allowed to smoke 2 (12%)
I was offered a nicotine substitute 0 (0%)
I was not offered anything to cope with not smoking 11 (65%)

Q29 Were you offered anything to read?

Yes 2 (12%)
No 15 (88%)

Q30 Was someone informed of your arrest?

Yes 6 (35%)
No 9 (53%)
I don't know 1 (6%)
I didn't want to inform anyone 1 (6%)

Q31 Were you offered a free telephone call?

Yes 9 (53%)
No 8 (47%)

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

My telephone call was not denied 11 (69%)
Yes 0 (0%)
No 5 (31%)

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 (9%)	10 (91%)
Contacting your partner, relative or friend	7 (47%)	8 (53%)
Contacting your employer	3 (27%)	8 (73%)
Where you were going once released	5 (42%)	7 (58%)

Q34 Were you offered free legal advice?

Yes 14 (100%)
No 0 (0%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice 0 (0%)
Yes 8 (67%)
No 4 (33%)

Q36 Were you interviewed by police about your case?

Yes 16 (100%)
No 0 (0%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	1 (6%)
Yes	12 (75%)
No	3 (19%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	3 (19%)
Yes	4 (25%)
No	9 (56%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	5 (33%)
Yes	3 (20%)
No	7 (47%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	9 (60%)
No	6 (40%)

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

Yes	4 (27%)
No	11 (73%)

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 (79%)	*Because of your crime*	2 (14%)
Insulting remarks (about you, your family or friends)	1 (7%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	2 (14%)	*Because you have a disability*	2 (14%)
Sexual abuse	0 (0%)	*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*	0 (0%)
Drugs	2 (14%)		

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

Yes	7 (44%)
No	6 (38%)
I wasn't handcuffed	3 (19%)

Q45 Were you restrained while in the police custody suite?

Yes	6 (40%)
No	9 (60%)

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

Yes	5 (31%)
No	11 (69%)

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

Yes	3 (19%)
No	13 (81%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
1 (6%)	4 (25%)	4 (25%)	4 (25%)	2 (13%)	1 (6%)

Section 4: Health care

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

Yes	6 (38%)
No	8 (50%)
Don't know	2 (13%)

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

	Yes	*No*
Doctor	3 (20%)	12 (80%)
Nurse	3 (20%)	12 (80%)
Paramedic	0 (0%)	13 (100%)

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

Yes	3 (19%)
No	7 (44%)
Don't know	6 (38%)

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

Yes	5 (31%)
No	11 (69%)

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

Not taking medication	11 (69%)
Yes	1 (6%)
No	4 (25%)

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

Yes	9 (60%)
No	6 (40%)

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

I didn't have any drug/alcohol problems	6 (46%)
Yes	3 (23%)
No	4 (31%)

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

I didn't have any drug/alcohol problems	6 (40%)
Yes	2 (13%)
No	7 (47%)

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*
11 (69%)	1 (6%)	1 (6%)	1 (6%)	0 (0%)	2 (13%)

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

Yes 5 (31%)
No 11 (69%)

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

Yes 5 (31%)
No 11 (69%)

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 11 (69%)
Yes 0 (0%)
No 5 (31%)

Prisoner survey responses for Waltham Forest 2012

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

		Waltham Forest police custody 2012	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		17	1805
SECTION 1: General information			
3	Are you under 21 years of age?	**0%**	**10%**
4	Are you Transgender/Transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**48%**	**30%**
6	Are you a foreign national?	**47%**	**14%**
7	Are you Muslim?	**0%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**30%**	**19%**
10	Have you been in police custody before?	**87%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**70%**	**67%**
12	Were you told your rights when you first arrived?	**70%**	**79%**
13	Were you told about PACE?	**32%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**22%**	**29%**
15	Could you use a toilet when you needed to?	**100%**	**90%**
16	If you used the toilet, was toilet paper provided?	**36%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**36%**	**31%**
17b	Ventilation/air quality?	**34%**	**22%**
17c	Temperature?	**27%**	**15%**
17d	Lighting?	**73%**	**44%**
18	Was there any graffiti in your cell when you arrived?	**46%**	**56%**
19	Did staff explain the correct use of the cell bell?	**27%**	**22%**
20	Were you held overnight?	**100%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**62%**	**86%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**78%**	**55%**
23	Were you offered a shower?	**0%**	**9%**
24	Were you offered a period of outside exercise?	**6%**	**6%**
25a	Were you offered anything to eat?	**75%**	**81%**
25b	Were you offered anything to drink?	**66%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**29%**	**9%**
27	Was the food/drink you received suitable for your dietary requirements?	**27%**	**44%**

Key to tables

		Waltham Forest police custody 2012	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?	12%	7%
29	Were you offered anything to read?	12%	13%
30	Was someone informed of your arrest?	36%	43%
31	Were you offered a free telephone call?	52%	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?	9%	14%
33b	Contacting your partner, relative or friend?	47%	53%
33c	Contacting your employer?	27%	20%
33d	Where you were going once released?	42%	31%
34	Were you offered free legal advice?	100%	87%
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	67%	69%
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	80%	75%
38	Was an appropriate adult present when you were interviewed?	32%	26%
39	Was an interpreter present when you were interviewed?	30%	14%
SECTION 3: Safety			
41	Did you feel unsafe?	41%	39%
42	Has another detainee or a member of staff victimised you?	27%	31%
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	7%	16%
43b	Physical abuse (being hit, kicked or assaulted)	15%	10%
43c	Sexual abuse	0%	4%
43d	Your race or ethnic origin	0%	3%
43e	Drugs	15%	9%
43f	Because of your crime	15%	8%
43g	Because of your sexuality	0%	0%
43h	Because you have a disability	15%	2%
43i	Because of your religion/religious beliefs	0%	2%
43j	Because you are from a different part of the country than others	0%	4%
44	Were your handcuffs removed on arrival at the police station?	54%	73%
45	Were you restrained while in the police custody suite?	41%	18%
46	Were you injured while in police custody, in a way that was not your fault?	32%	23%
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?	32%	30%

Key to tables

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SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**38%**	**34%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**21%**	**45%**
51b	Nurse	**21%**	**20%**
	Percentage seen by either a doctor or a nurse	**32%**	**52%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**19%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**32%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**20%**	**37%**
55	Did you have any drug or alcohol problems?	**59%**	**53%**
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?	**43%**	**43%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**22%**	**15%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**40%**	**30%**
59	Did you have any specific physical health care needs?	**32%**	**32%**
60	Did you have any specific mental health care needs?	**32%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	**24%**