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

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by

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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.

Some aspects of strategic oversight in Redbridge needed to be improved and further work was needed on quality assurance processes. Staffing was mainly by sergeants on short placements in custody but there was an ongoing need to provide shift relief staff to cover absences. There was good partnership working, but a lack of meaningful monitoring of the use of force.

The facilities were well maintained, although there was a problem with graffiti at Barkingside. Interactions with detainees were mixed, and some were poor. There was limited attention to diversity. The quality of risk assessments was mixed, and sometimes inadequate, but risk management seemed appropriate. The quality of handovers between shifts, and pre-release risk assessments were poor. Some basic hygiene needs were provided only 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. There were limited options to provide appropriate adults for juveniles and vulnerable adults if relatives or friends were not available. Detainees were not routinely told how to make a complaint and the arrangements for taking complaints were poor.

Clinical governance arrangements for FMEs were inadequate. Substance misuse services were poor, as were medicines management and medical rooms, which required urgent attention. There were no mental health diversion services but detainees were not held under section 136 of the Mental Health Act.

Overall, custody provision in Redbridge was disappointing. This report sets out a number of recommendations that we hope will assist the MPS and the Mayor's Office for Policing and Crime to improve facilities. We expect an action plan to be provided in due course.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

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March 2012

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

2. Background and key findings

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

2.2 This unannounced inspection was conducted at police custody suites in the MPS borough operational command unit (BOCU) of Redbridge. We examined force-wide and BOCU custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites. Redbridge custody suite, located in Ilford, had 17 cells and was open 24 hours a day. There was a standby custody suite at Barkingside which had seven cells and was used as an overspill facility and for specific operations conducted by Redbridge and other MPS officers. We were told that Barkingside was due to close in the near future as part of the MPS custody estates strategy. The BOCU had received 4,221 detainees in the period from 1 July 2011 to 30 January 2012. In the same period, 95 immigration detainees had been held at the custody suite.

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

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

Strategy

2.5 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.

2.6 Some aspects of strategic oversight of custody within the BOCU needed to be improved. Some reasonable quality assurance mechanisms were in place but needed further work. Sergeants were on a three-month placement in custody but there were gaps in the designated detention officer (DDO) complement. All staff working in custody had been trained. Partnership arrangements were good.

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

Treatment and conditions

2.7 Staff interactions with detainees were mixed, and some were poor. Awareness of diversity issues was limited. Detainees were routinely asked if they had any dependency obligations.

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

2.9 The physical conditions were reasonable and no ligature points were found. 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

2.10 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.

2.11 Legal assistance was offered. Children were not held in custody under section 46 of the Children Act 1989.[3] Immigration detainees were kept in police custody for long periods. Professional interpreting services were generally used when needed, although we observed exceptions to this.

2.12 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 limited options available to provide one.

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

Health care

2.14 Primary health services were adequate but there were sometimes delays in the arrival of forensic medical examiners (FMEs) when they were called. Clinical governance arrangements for FMEs were inadequate.

2.15 Medicines management arrangements and medical rooms needed urgent attention. 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 poor. There were no mental health diversion services but no detainees were held under section 136 of the Mental Health Act 1983. [4]

[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.

[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.

Main recommendations

2.16 All staff should deal with detainees in a professional and respectful manner.

2.17 Comprehensive risks assessments should be completed with all new arrivals into custody, and before the release of those deemed vulnerable.

2.18 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

2.19 Appropriate adults should be available to support without undue delay, juveniles in custody aged 17, including availability out of hours.[5]

[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.

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 the day-to-day management of Redbridge's custody suites 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 and Redbridge operational command unit (OCU). 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 BOCU SMT members paid regular visits to the custody suite, with staff reporting good visibility of the SMT in custody. A chief inspector had day-to-day responsibility for custody and was supported by a small custody support team, which included a custody manager, who was an inspector. In addition to managing the custody suites, the custody manager had other portfolio responsibilities and covered as duty officer for the borough on an infrequent basis.

3.5 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. Not all of the risks identified were being effectively managed.

3.6 Custody issues were an agenda item at SMT level during daily management meetings and by exception at quarterly health and safety meetings. The custody manager regularly attended meetings hosted by the CJD. There were no formal meetings between custody staff, such as a custody user group.

3.7 The custody suite at Ilford was staffed by permanent custody sergeants but there was no resilience within the permanent team and this had to be provided by trained staff from operational patrol teams. DDOs looked after the ongoing care and welfare of detainees; however, as the borough did not have its full complement of DDOs, police constable (PC) gaolers were widely used. The suite at Barkingside was staffed by sergeants from operational patrol teams. DDOs and PC gaolers were supervised by their team's custody sergeants. Sergeants working in custody were line managed by operational team inspectors.

3.8 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.

3.9 Quality assurance checks were carried out by the custody support team, who were required to dip-sample approximately 10% of custody records per month. These checks followed a set checklist but were mainly a 'tick box' exercise. The custody manager dip-sampled custody records, to review the quality of inspector reviews, and also CCTV recordings; however, CCTV had not been viewed for three months. When the custody manager identified areas for development, he fed them back to the relevant member of staff; similarly, when he found trends, he brought them to the attention of all custody-trained staff. There was no dip-sampling of PER forms, to ensure that risk and vulnerability data were accurately recorded to inform other agencies.

Recommendation

3.10 Quality assurance checks should include more qualitative information on outcomes for detainees, utilise closed-circuit television and cover person escort records (PERs).

Partnerships

3.11 Partnership arrangements were described as good, with active engagement with relevant criminal justice and health partners.

3.12 There was an MOPC lead for the ICV scheme, which was viewed by all parties as an important independent oversight mechanism. ICVs from the Havering and Redbridge panel visited Ilford and Barkingside (when open) regularly, although had not reached their annual target of visits to Ilford during 2011. They prepared a feedback report after each of their visits, and summary reports for quarterly ICV panel meetings were produced by a member of the MPA administrative staff; we were told that this would continue under the MOPC. 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 panel coordinator and custody manager reported good relationships between ICVs and custody staff, and the custody manager regularly attended ICV quarterly meetings.

Learning and development

3.13 All DDOs and sergeants performing the role of custody officer had received MPS-approved custody training, which was delivered corporately. There was no system for ensuring that sergeants received refresher training and the custody manager did not keep records of when sergeants had last been trained. PC gaolers were required to complete a computer-based training package before working in custody; however, the quality assurance of this process and the system for ensuring that only trained PCs were posted into custody was not robust or clear. All staff received annual first-aid and personal safety refresher training, which was delivered centrally.

Recommendation

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

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 There was a good diverse mix in the custody staff group at the time of the inspection. Some custody staff were respectful in their interactions with detainees, using first or preferred names routinely and checking that detainees understood the booking-in process. Other custody staff we observed were abrasive, focused on the computer screen and made no attempt to engage positively with detainees. One custody sergeant did little to calm down an agitated detainee's behaviour, resulting in a confrontational exchange. We also observed some custody staff having conversations with each other and with other police staff about non-custodial issues in the full hearing of detainees. Some staff demonstrated a sense of apathy and disinterest; examples of this included call bells not being responded to (see paragraph 4.28), telephones being ignored and custody sergeants being unwilling to assist DDOs, who were often very busy (see main recommendation 2.16).

4.2 Most custody sergeants managed movements in the custody area reasonably well. We observed a sergeant clearing the booking-in area when dealing with a fractious detainee and limiting the number of people at the booking-in desk. This area was very noisy when more than one detainee was being booked in and staff tried to mitigate this by inviting detainees to stand close to the desk. Nevertheless, detainees were asked personal questions in the full hearing of others

4.3 All detainees were asked about dependency issues and whether they had specific cultural or religious needs. There was little awareness of the distinct needs of minority groups, and a 'one-size fits all' approach was adopted. Custody staff had completed only basic diversity training during their initial custody training course; they told us that they had developed their understanding of different cultures and ethnicities from practical experience.

4.4 Female detainees were given the opportunity to speak to a female member of staff but one 15-year-old female detainee we spoke to was not clear why she had been offered this and consequently declined the offer. She was not placed in the care of a female officer and when we asked staff why not, staff were unaware of this requirement.

4.5 Juveniles were generally treated the same as adult detainees, except that they were held in one of four detention rooms which were located in close proximity to the booking-in desk. We observed a 15-year-old detainee being held in a detention room for over 15 hours, waiting for her AA to arrive, with no interaction from staff other than routine checks. Although her detention was reviewed, little was done to ensure her well-being; she was cold in her cell, and it was only when we intervened that staff provided her with another blanket and a hot drink. Staff were not aware of safeguarding procedures for juveniles or vulnerable adults, and were not confident about being able to refer someone if they identified a concern.

4.6 There was no provision for the hard of hearing, although custody staff were aware of colleagues they could call on who were trained in the use of sign language. There were no adapted cells for detainees with disabilities. Holy books were available on request.

Recommendations

4.7 Arrangements in booking-in areas should allow for private communication between detainees and staff.

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

4.9 Staff should receive up-to-date awareness training about child protection and safeguarding of juveniles and vulnerable adults.

Safety

4.10 Custody sergeants and DDOs carried out initial risk assessments. Their approach to these assessments was often mechanistic and rushed (see main recommendation 2.16). It was not clear from the custody record or risk assessment whether the Police National Computer (PNC) had been checked for relevant information, although we were aware of this happening. In our survey, more detainees at Ilford (55%) than at comparator custody suites (39%) reported feeling unsafe. The poor quality of some interactions we saw may have been a significant contributory factor to this.

4.11 Our custody record analysis showed that risk assessments were reviewed and amended appropriately. DDOs understood the type of response they should obtain when conducting rousing checks, and detainees brought in to custody intoxicated were placed on 30-minute observations. However, in our custody record analysis we found two cases where rousing had been prescribed but not carried out (or recorded). Levels of observation were not always indicated on the risk assessments but were recorded in the custody log. In most custody records we reviewed, these were appropriate. Nine cells were monitored by CCTV at Ilford, and staff told us that they placed vulnerable detainees in these cells for additional monitoring.

4.12 DDOs routinely checked vacated cells for any unauthorised items. All custody staff carried anti-ligature knives and additional knives were held behind the custody desk. Detainees were not routinely required to remove garments that had cords attached. Some of the PERs we reviewed did not contain sufficient information about the self-harm markers that had been highlighted, and there were no quality assurance arrangements for PERs (see recommendation 3.10).

4.13 Staff handovers took place at the end of each shift but they varied in quality. In one handover we observed, the custody sergeant cleared the custody area, printed off the national strategy for police information systems (NSPIS) 'whiteboard' and went through each case with the incoming custody sergeants. Another we saw at night did not allow for an effective handover, as the discussion took place in front of detainees. DDOs had a separate handover.

4.14 Custody sergeants completed pre-release risk assessments. Our custody record analysis showed that most of these recorded 'no issues'. In some records, pre-release action taken had been recorded in the log but not in the pre-release risk assessment. In most instances detainees were offered a leaflet containing a range of agency contact details but it was available only in English. We observed an alcohol-dependent female detainee being bailed who was so unwell that an ambulance had to be called. There was no pre-release planning for her, despite the fact that she had been in custody for a long period, had been seen twice by the FME and was very vulnerable (see main recommendation 2.17).

Recommendations

4.15 Rousing should always take place when needed.

4.16 PERs should contain detailed information about any self-harm markers.

4.17 Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees.

Use of force

4.18 All staff had been trained in approved safety techniques and received annual refresher training. Custody staff told us that detainees would be examined by a qualified health care professional after the use of force only if they had an injury.

4.19 Most detainees were brought to the custody suite without handcuffs. Custody sergeants gathered information about detainees who were brought in handcuffed and assessed when they could be removed appropriately.

4.20 Custody staff were able to recall occasions when force had been used in the custody suite to locate a detainee in a cell or restrain a fractious detainee but this information was recorded only on the custody log; there was no central recording of the use of force, so the borough was not able to analyse the data and identify trends.

4.21 We observed detainees being searched appropriately and respectfully. MPS data showed that, between July 2011 and January 2012, 21% of detainees at Ilford had been strip-searched, which was a higher figure than in some comparable MPS boroughs. In our custody record analysis this was even higher, with 27% of detainees being strip-searched. While we did not observe anything untoward, this needed examination by the SMT.

Recommendations

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

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

Physical conditions

4.24 The cells at Ilford were clean and in good repair, with no evident ligature points and little graffiti. The situation at Barkingside was similar, although we found more graffiti in cells. There was insufficient natural light in the cells and cell lights were kept on. We were told that DDOs checked the conditions of the cells daily but the records we looked at were incomplete and staff were unable to account for the gaps.

4.25 Staff at Ilford reported defects promptly, to limit the number of cells out of use, and had a system for reporting spillages that could be dealt with only by specialist cleaners. Showers and washbasins were clean. Deep cleaning of the custody suite took place every three months.

4.26 Staff told us that regular maintenance checks were undertaken but poor recording made it difficult to verify the frequency and outcomes of these checks. There was no evidence of quarterly or annual checks being carried out.

4.27 Cell keys were located behind the custody desk and we observed non-custody staff requesting and taking keys to visit detainees in their cells unaccompanied.

4.28 Cell call bells were checked as part of the daily cell checks and could be answered only by the custody staff attending the cell. On one occasion, the DDOs were busy in the custody suite and a call bell was left ringing for several minutes until a custody sergeant reluctantly left the custody desk to respond to it. Detainees we spoke to told us that the use of the call bell had not been explained to them, although most were aware of its function.

4.29 There was a fire evacuation policy but it was not possible to ascertain when the most recent fire drill had taken place and custody staff we spoke to could not recall having been involved in practice evacuations. Staff were aware of their duties in such an event and were able to locate the handcuffs they would use for detainees in custody and the location of the rendezvous point. Smoking was not allowed in the custody suite.

Recommendations

4.30 The borough operational command unit should ensure that regular maintenance inspection checks of the facilities are carried out, including quarterly and annual checks. All cell checks should always be recorded.

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

4.32 Correct use of cell call bells should be explained to all detainees and they should be responded to promptly.

Housekeeping point

4.33 Regular fire evacuation drills should be conducted and recorded.

Detainee care

4.34 Detainees were provided with a mattress, pillow and clean blanket. Mattresses and pillows were not wiped down between uses. There were two showers, with appropriate screening, but custody staff told us that they would offer a shower only if a detainee had spent 24 hours in the custody suite, or on request. No detainees in our survey reported having been offered a shower, and in our custody record analysis this was also the case, even though 10 had subsequently gone to court. Only paper towels were available. Hygiene items such as toothbrushes, toothpaste, soap and razors were available but female detainees were not routinely offered feminine hygiene products. The in-cell toilets were clean but toilet paper was provided only on request, and the detainees we spoke to had not been told how they could obtain it. In cells containing CCTV coverage, the toilet area was adequately obscured on monitors.

4.35 There was a reasonable stock of replacement clothing, although underwear was not available. We observed one detainee who came into the custody suite barefoot being offered a pair of

plimsolls from a wide range of sizes. Staff told us that family and friends could bring in replacement clothing but custody sergeants seemed reluctant to offer the jogging suits that they held in stock for such detainees.

4.36 Detainees were not always asked when they had last eaten, although we observed one custody sergeant offering each detainee that he booked in a meal or a drink. Meals were offered at recognised mealtimes, provided from the staff canteen when open. At other times, microwave meals were used. These were stored and prepared in a well-equipped and clean kitchen, with clear cooking instructions. Although the selection of such meals was limited, they were mainly offered to detainees only in the evenings and weekends. A range of dietary and religious needs were provided for. Most detainees in our custody record analysis (77%) had been offered at least one meal while in custody.

4.37 The exercise yard was rarely used and detainees were not routinely offered time in the fresh air, even if they had been in custody for a long time. We found only one record that showed that the detainee had been given outside exercise. There were no reading materials available to detainees. Visits to detainees from family members were not encouraged due to the lack of visiting facilities.

Recommendations

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

4.39 Appropriate replacement clothing should be given to detainees to wear when their clothes or footwear are removed, and replacement underwear should be made available.

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

Housekeeping points

4.41 Mattresses should always be wiped down between uses.

4.42 Toilet paper should be available in each cell, and all female detainees should be informed that sanitary products are available if they need them.

4.43 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.

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

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 There was no apparent focus on alternatives to arrest. Most custody sergeants told us that on rare occasions they had refused to detain but were unable to cite any examples. One custody sergeant said that he had never refused to detain anyone brought to the custody suite. In our survey, 86% of detainees had spent more than 24 hours in the suite, compared with the comparator of 67%. Although we observed custody staff actively liaising with police officers to minimise the time that detainees spent in custody, they were not always able to move investigations forward promptly.

5.2 We were told that there was a good relationship with UK Border Agency staff and that this enabled immigration detainees to be moved to more appropriate facilities quickly. However, MPS data showed that, on average, immigration detainees were held for 34 hours at Ilford, compared with 17.5 hours in the neighbouring borough of Waltham Forest.

5.3 A leaflet specifying detainees' rights in relation to PACE, translated into a range of languages, was available on the MPS intranet but it was not available in other formats, such as easy read. A telephone interpreting service was available; although there had been a two-handset telephone in use at the booking-in desk for this purpose, we were told that it was broken and had not been replaced. This meant that when the interpreting service was in use, detainees had to stand several feet away from the booking-in desk to speak to the interpreter via another telephone. We observed a detainee being booked in whose English was very limited and who was known to have attempted self-harm previously. Even though the detainee and the custody sergeant struggled to understand each other, the custody sergeant did not consider it necessary to use the interpreting service.

5.4 We were assured that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989.

5.5 Children and young people under the age of 17 were not interviewed unless an AA was present. 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 (see recommendation 2.19). Staff told us that they usually tried to find relatives to act as AAs for juveniles and vulnerable adults. When this was not possible, they requested an AA via the local social services emergency duty team; however, we were told of delays of four to five hours in obtaining AAs during office hours, with longer waits out of hours and at weekends. Sometimes custody staff had involved members of the public to act as AAs, including staff from a nearby shop, who were not trained for the role. Custody sergeants told us that they normally consulted health care staff when assessing whether or not a vulnerable adult needed an AA. We were told that an AA scheme was in the process of being set up by the police.

5.6 Staff told us that whenever a juvenile was refused bail, they always contacted the local authority but that, in practice, facilities were never available to place juveniles in PACE remand

beds or remand foster placements. This sometimes resulted in children being held in custody overnight unnecessarily.

Recommendations

5.7 Senior police officers should engage with the UK Border Agency locally to ensure that the time spent in police custody by immigration detainees is minimised.

5.8 Staff should use the telephone interpreting service when there are difficulties communicating in English.

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

5.10 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.

Housekeeping points

5.11 The MPS should further develop and promote alternatives to custody approaches.

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

5.13 The two-handset telephone should be reinstated.

Rights relating to PACE

5.14 Detainees' right to free legal representation was explained to them. However, we observed some detainees who declined legal advice during booking-in not being asked the reasons why, although they were all reminded that they could change their mind at any time. In our custody record analysis, of 15 detainees who had declined the offer of legal advice, the reason for this had been recorded in 10 cases. Eleven of these 15 detainees had been held for over six hours, and records showed that two of them had not been reminded of their right to legal advice.

5.15 Detainees were provided with a 'notice of rights and entitlements' and could consult the PACE codes of practice, two copies of which were available; however, detainees were not shown these and it was not clear that those with little experience of police custody would understand what they were being offered. Legal representatives could easily obtain copies of detainees' custody records. A legal representative we spoke to told us that PACE was complied with efficiently and fairly, and that he felt that detainees were well looked after.

5.16 Detainees were told that they could have someone informed of their whereabouts, although custody records did not show whether or not the calls had been made. However, we observed some detainees being allowed to use the telephone. Detainees were not interviewed while under the influence of drugs or alcohol.

5.17 In our custody record analysis, reviews of detention were, in most cases, held in accordance with statutory requirements. We observed reviews that were appropriately focused on compliance with PACE, although in one instance the inspector appeared to show little concern

about the detainee's general well-being. In several cases, reviews had been undertaken while the detainee had been asleep and there was not always evidence that detainees had later been informed of these reviews.

5.18 The management of DNA and forensic samples was generally sound and there was an effective process for prompt collection of samples.

5.19 Court cut-off times were reasonable, being 2pm on weekdays, with some flexibility, and 8am on Saturdays.

Housekeeping points

5.20 Detainees who decline the services of a solicitor should be asked the reasons for their decision and these should be noted in the custody record.

5.21 Up-to-date copies of the PACE codes of practice C should be shown to detainees and their purpose explained during booking-in.

5.22 Staff should ensure that detainees who want someone informed of their whereabouts can, subject to investigative considerations, have the request met and that it is recorded in the custody log.

5.23 Staff should ensure that detainees are always informed, on waking, if a review of their detention has taken place while they were asleep.

Rights relating to treatment

5.24 There was no clear process for making complaints; some staff told us that inspectors took complaints while the detainee was still in custody, while others told us that detainees who wished to complain were sent to the front desk to do so, which would not be an option for detainees denied bail. There were no notices about the IPCC complaints process. The borough received information on complaints but there was no breakdown of those which related to custody.

Recommendation

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

6. Health care

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

Governance

6.1 Primary health services were provided by FMEs. There was a contract in place between individual FMEs and the Police Authority (with the intention that the services were provided for the Commissioner within the Metropolitan Police Forensic Medical Service). Substance misuse services were provided by Redbridge Council, and mental health services by the North East London Mental Health Foundation Trust (NELFT).

6.2 Although 46% of respondents to our survey told us that they had seen an FME while in custody, we were unable to speak to any such detainees. We were told that clinical governance policies were in place but were unable to verify whether FMEs were aware of them or adhered to them.

6.3 Detainees who did not speak English had access to a telephone interpreting service and staff told us that Asian officers were also used as interpreters where appropriate. Female police staff acted as chaperones, if required, for female patients.

6.4 The clinical room at Ilford was dirty, untidy and generally poorly kept. This had been recognised in a recent audit by the MPS CJD within the Territorial Policing Directorate; the response from the BOCU stated: 'This has been thoroughly cleaned. Cleaners sign book daily and fulfil contract'. However, we found this not to be true; there was thick dust at high level, notices were stuck to the walls with hazard tape, the couch was torn and there were no paper hand towels or couch covers. Sharps bins were not signed or dated on assembly. We did not see an infection control policy, infection control audits or cleaning schedules for the room. The room at Barkingside was similar; it was cramped, dirty and the couch was the wrong way round. We found forensic sampling kits that were over a year out of date. However, the sharps bin had been signed and dated.

6.5 Resuscitation equipment was available in sealed bags at both suites and staff knew where these were kept. Equipment included a defibrillator and was checked daily at Ilford but we could find no evidence of checks at Barkingside, where two sets of defibrillator pads had expired. Staff told us that custody sergeants received cardiopulmonary resuscitation (CPR) training/updates annually and that DDOs received CPR training yearly.

Recommendation

6.6 All clinical rooms should be fit for purpose and meet infection control standards.

Housekeeping point

6.7 All disposable equipment should be in date and ready for use.

Patient care

6.8 In our survey, 40% of those who had seen a health care professional rated the quality of care as good or very good. Custody staff had access to an FME rota on the force intranet and called the FME directly. We were told that the FME also covered three other boroughs. In our review of custody records, 14 (47%) detainees had been seen by the FME. The longest wait had been approximately three hours 22 minutes; the average had been approximately one hour 15 minutes, although six detainees had been seen within 11 minutes of the FME being called. However, we found one example of a detainee who reported that he suffered from depression and had taken non-prescribed antidepressants before arriving into custody. He had been held for over 50 hours and not seen a health care professional. There was no evidence that such delays were monitored or investigated.

6.9 Contact between the FME and detainees was recorded on the NSPIS custody record in most cases. However, we were unable to ascertain how or where FMEs kept their own comprehensive, contemporaneous records or whether they obtained the detainee's consent to share information with the police or other health professionals.[6]

6.10 At Barkingside, we found a medical records book (Book 83) left out on the desk in the FME room that had been started in 2009, although it contained entries from the previous fortnight. These records had not been transcribed onto NSPIS records, resulting in an incomplete record of the detainees' stay in custody. We brought this to the attention of senior staff, who told us that Edmonton BOCU had been using the suite at the time these cases had occurred.

6.11 Medicines were stored in a locked cupboard in the FME room. All custody staff had access to these keys. Records were kept of the use of diazepam and dihydrocodeine tablets, which were correct when we checked them. FMEs left medicines for administration in small evidence bags that were clipped to custody records; there was a flag on NSPIS to remind staff when they were due. Two DDOs administered the medications and acknowledged these against the prescription on NSPIS.

6.12 Custody staff made attempts to retrieve prescribed medications from a detainee's home where possible but 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

6.13 Detainees should receive prescribed medication to treat any clinical signs, symptoms or conditions.

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

6.15 All detainee records should provide a complete record of care and interactions while in custody.

[6] 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.

Substance use

6.16 In our survey, 51% of respondents said that they had had a substance misuse issue on arrest, of whom 60% had seen a drug or alcohol support worker while in custody. The service was provided by Redbridge Council and was limited to those with a class A drug issue who either tested positive on arrest or who asked to see a drug worker. Workers provided cover in the suite from 7am until 10pm during the week and from 9am until 5pm at weekends. Drug workers and their managers were adamant that they would not see those with alcohol or class B drug issues or juveniles because, they said, 'we do not get credits for them, it is not a KPI'.

6.17 Detainees were assessed in private in the custody suite. Drug workers could refer detainees to the local NHS prescribing service or a structured day programme if appropriate. Brief intervention sessions and harm minimisations advice were also offered. Workers told us that there was no needle exchange programme available in custody and led us to believe that there were no programmes in the local area, although subsequently we found out that there was a comprehensive needle exchange scheme in local pharmacies.

6.18 Drug workers told us that they had a good relationship with the custody staff, who were supportive of their role.

Recommendation

6.19 All detainees should have access to a drugs or alcohol arrest referral worker as needed.

Housekeeping point

6.20 Detainees being released into the community should be given clean injecting equipment if required.

Mental health

6.21 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 but staff were not aware of a formal policy for this and reported some delays, especially out of hours. In our survey, 26% of respondents said that they had specific mental health needs but only 9% of them had been seen by a mental health professional (see main recommendation 2.18).

6.22 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.

6.23 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 within the Territorial Policing Directorate confirmed this claim. 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.

6.24 Staff at NELFT described their partnership with the police as good and told us that the police generally gave them notice before arriving with section36 patients. Management data on the use of the section 136 suite were kept by NELFT and showed that about 100 detainees per year were taken there from Redbridge, 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 up in the community as outpatients.

7. Summary of recommendations

Main recommendations

7.1 All staff should deal with detainees in a professional and respectful manner. (2.16)

7.2 Comprehensive risks assessments should be completed with all new arrivals into custody, and before the release of those deemed vulnerable. (2.17)

7.3 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. (2.18)

National issues

7.4 Appropriate adults should be available to support without undue delay, juveniles in custody aged 17, including availability out of hours. (2.19)

Recommendations

Strategy

7.5 Quality assurance checks should include more qualitative information on outcomes for detainees, utilise closed-circuit television and cover person escort records (PERs). (3.10)

7.6 All staff required to work in custody should be adequately trained, including regular refresher training. (3.14)

Treatment and conditions

7.7 Arrangements in booking-in areas should allow for private communication between detainees and staff. (4.7)

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

7.9 Staff should receive up-to-date awareness training about child protection and safeguarding of juveniles and vulnerable adults. (4.9)

7.10 Rousing should always take place when needed. (4.15)

7.11 PERs should contain detailed information about any self-harm markers. (4.16)

7.12 Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.17)

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

7.14 Strip-searching should be more closely monitored and the reasons for its apparently disproportionate use should be addressed. (4.23)

7.15 The borough operational command unit should ensure that regular maintenance inspection checks of the facilities are carried out, including quarterly and annual checks. All cell checks should always be recorded. (4.30)

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

7.17 Correct use of cell call bells should be explained to all detainees and they should be responded to promptly. (4.32)

7.18 All detainees held overnight, or who require one, should be offered a shower and be provided with a cotton towel. (4.38)

7.19 Appropriate replacement clothing should be given to detainees to wear when their clothes or footwear are removed, and replacement underwear should be made available. (4.39)

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

Individual rights

7.21 Senior police officers should engage with the UK Border Agency locally to ensure that the time spent in police custody by immigration detainees is minimised. (5.7)

7.22 Staff should use the telephone interpreting service when there are difficulties communicating in English. (5.8)

7.23 Appropriate adults should be available to support children and vulnerable adults in custody, including out of hours, without undue delay. (5.9)

7.24 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. (5.10)

7.25 Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody. Data about complaints should be monitored. (5.25)

Health care

7.26 All clinical rooms should be fit for purpose and meet infection control standards. (6.6)

7.27 Detainees should receive prescribed medication to treat any clinical signs, symptoms or conditions. (6.13)

7.28 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott principles. (6.14)

7.29 All detainee records should provide a complete record of care and interactions while in custody. (6.15)

7.30 All detainees should have access to a drugs or alcohol arrest referral worker as needed. (6.19)

Housekeeping points

Treatment and conditions

7.31 Regular fire evacuation drills should be conducted and recorded. (4.33)

7.32 Mattresses should always be wiped down between uses. (4.41)

7.33 Toilet paper should be available in each cell, and all female detainees should be informed that sanitary products are available if they need them. (4.42)

7.34 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. (4.43)

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

Individual rights

7.36 The MPS should further develop and promote alternatives to custody approaches. (5.11)

7.37 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.12)

7.38 The two-handset telephone should be reinstated. (5.13)

7.39 Detainees who decline the services of a solicitor should be asked the reasons for their decision and these should be noted in the custody record. (5.20)

7.40 Up-to-date copies of the PACE codes of practice C should be shown to detainees and their purpose explained during booking-in. (5.21)

7.41 Staff should ensure that detainees who want someone informed of their whereabouts can, subject to investigative considerations, have the request met and that it is recorded in the custody log. (5.22)

7.42 Staff should ensure that detainees are always informed, on waking, if a review of their detention has taken place while they were asleep. (5.23)

Health care

7.43 All disposable equipment should be in date and ready for use. (6.7)

7.44 Detainees being released into the community should be given clean injecting equipment if required. (6.20)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Vinnett Pearcy	HMIP inspector
Peter Dunn	HMIP inspector
Fiona Shearlaw	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 Redbridge, 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 Redbridge police station was created, listing all those who had arrived from Redbridge Magistrates' court within the previous two months.

Selecting the sample

In total, 92 respondents were approached. Thirty-nine reported being held in police stations outside of Redbridge and three could speak no English, and so it was not possible to determine the police station they had been in. On the day, the questionnaire was offered to 50 respondents; there were two refusals and seven 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 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, 41 (82%) 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?**
Redbridge, Ilford

Q3 **How old are you?**

16 years or younger	0 (0%)	*40-49 years*	6 (15%)
17-21 years	4 (10%)	*50-59 years*	0 (0%)
22-29 years	22 (55%)	*60 years or older*	0 (0%)
30-39 years	8 (20%)		

Q4 **Are you:**

Male	41 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 **What is your ethnic origin?**

White - British	16 (39%)
White - Irish	2 (5%)
White - other	3 (7%)
Black or black British - Caribbean	7 (17%)
Black or black British - African	4 (10%)
Black or black British - other	1 (2%)
Asian or Asian British - Indian	3 (7%)
Asian or Asian British - Pakistani	2 (5%)
Asian or Asian British - Bangladeshi	1 (2%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	1 (2%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (2%)

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

Yes	5 (14%)
No	31 (86%)

Q7 **What, if any, is your religion?**

None	3 (8%)
Church of England	9 (24%)
Catholic	9 (24%)
Protestant	1 (3%)
Other Christian denomination	5 (14%)
Buddhist	1 (3%)
Hindu	1 (3%)
Jewish	0 (0%)

Muslim 4 (11%)
Sikh 4 (11%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 40 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q9 Do you consider yourself to have a disability?
Yes 8 (20%)
No 32 (80%)

Q10 Have you ever been held in police custody before?
Yes 40 (100%)
No 0 (0%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 6 (15%)
More than 24 hours, but less than 48 hours (2 days) 26 (63%)
More than 48 hours (2 days), but less than 72 hours (3 days) 8 (20%)
72 hours (3 days) or more 1 (2%)

Q12 Were you told your rights when you first arrived there?
Yes 31 (78%)
No 8 (20%)
Don't know/can't remember 1 (3%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 20 (50%)
No 16 (40%)
I don't know what this is/I don't remember 4 (10%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 24 (59%)
I was offered a tracksuit to wear 3 (7%)
I was offered an evidence/paper suit to wear 8 (20%)
*I was **only** offered a blanket* 3 (7%)
Nothing 3 (7%)

Q15 Could you use a toilet when you needed to?
Yes 39 (95%)
No 2 (5%)
Don't know 0 (0%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 13 (33%)
No 27 (68%)

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

	Good	*Neither*	*Bad*
Cleanliness	8 (20%)	15 (38%)	17 (43%)
Ventilation/air quality	7 (19%)	13 (35%)	17 (46%)
Temperature	3 (8%)	10 (28%)	23 (64%)
Lighting	11 (31%)	12 (34%)	12 (34%)

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

Yes 25 (61%)
No 16 (39%)

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

Yes 4 (10%)
No 36 (90%)

Q20 **Were you held overnight?**

Yes 40 (98%)
No 1 (2%)

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

Not held overnight 1 (2%)
Pillow 18 (44%)
Blanket 31 (76%)
Nothing 4 (10%)

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

Not held overnight/did not get any bedding 5 (13%)
Yes 13 (34%)
No 20 (53%)

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

Yes 0 (0%)
No 40 (100%)

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

Yes 0 (0%)
No 41 (100%)

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	33 (85%)	6 (15%)
Drink?	36 (90%)	4 (10%)

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

Very good	*Good*	*Neither*	*Bad*	*Very Bad*	*N/A*
0 (0%)	4 (10%)	6 (15%)	10 (25%)	16 (40%)	4 (10%)

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

I did not have any food or drink 4 (10%)
Yes 16 (39%)

No 21 (51%)

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 3 (7%)
I was allowed to smoke 1 (2%)
I was offered a nicotine substitute 0 (0%)
I was not offered anything to cope with not smoking 37 (90%)

Q29 Were you offered anything to read?

Yes 3 (7%)
No 38 (93%)

Q30 Was someone informed of your arrest?

Yes 18 (45%)
No 16 (40%)
I don't know 2 (5%)
I didn't want to inform anyone 4 (10%)

Q31 Were you offered a free telephone call?

Yes 22 (54%)
No 19 (46%)

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

My telephone call was not denied 26 (65%)
Yes 2 (5%)
No 12 (30%)

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 (3%)	29 (97%)
Contacting your partner, relative or friend	23 (62%)	14 (38%)
Contacting your employer	1 (4%)	27 (96%)
Where you were going once released	11 (37%)	19 (63%)

Q34 Were you offered free legal advice?

Yes 36 (88%)
No 5 (12%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice 5 (13%)
Yes 20 (51%)
No 14 (36%)

Q36 Were you interviewed by police about your case?

Yes 38 (97%)
No 1 (3%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	3 (8%)
Yes	21 (54%)
No	15 (38%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	21 (54%)
Yes	5 (13%)
No	13 (33%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	22 (56%)
Yes	0 (0%)
No	17 (44%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	18 (45%)
No	22 (55%)

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

Yes	16 (39%)
No	25 (61%)

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

I have not been victimised	25 (61%)	*Because of your crime*	7 (17%)
Insulting remarks (about you, your family or friends)	9 (22%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	6 (15%)	*Because you have a disability*	3 (7%)
Sexual abuse	1 (2%)	*Because of your religion/religious beliefs*	2 (5%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	2 (5%)
Drugs	8 (20%)		

Please describe:

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

Yes	30 (75%)
No	10 (25%)
I wasn't handcuffed	0 (0%)

Q45 Were you restrained while in the police custody suite?

Yes	8 (21%)
No	31 (79%)

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

Yes	8 (21%)
No	30 (79%)

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

Yes	4 (10%)
No	36 (90%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
2 (5%)	5 (13%)	11 (29%)	10 (26%)	9 (24%)	1 (3%)

Section 4: Health care

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

Yes	12 (32%)
No	25 (66%)
Don't know	1 (3%)

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

	Yes	*No*
Doctor	18 (46%)	21 (54%)
Nurse	2 (8%)	24 (92%)
Paramedic	1 (4%)	24 (96%)

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

Yes	10 (27%)
No	22 (59%)
Don't know	5 (14%)

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

Yes	13 (33%)
No	26 (67%)

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

Not taking medication	26 (68%)
Yes	5 (13%)
No	7 (18%)

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

Yes	20 (51%)
No	19 (49%)

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	19 (49%)
Yes	12 (31%)
No	8 (21%)

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

I didn't have any drug/alcohol problems	19 (49%)
Yes	6 (15%)
No	14 (36%)

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*
18 (47%)	0 (0%)	8 (21%)	4 (11%)	6 (16%)	2 (5%)

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

Yes 11 (29%)
No 27 (71%)

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

Yes 10 (26%)
No 29 (74%)

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 30 (77%)
Yes 1 (3%)
No 8 (21%)

Prisoner survey responses for Redbridge Police custody suites 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

	Any percentage highlighted in green is significantly better	Redbridge Police custody Suites 2012	Police custody comparator
	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		41	1781
SECTION 1: General information			
3	Are you under 21 years of age?	**10%**	**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)?	**48%**	**30%**
6	Are you a foreign national?	**14%**	**15%**
7	Are you Muslim?	**11%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**20%**	**19%**
10	Have you been in police custody before?	**100%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**86%**	**67%**
12	Were you told your rights when you first arrived?	**78%**	**78%**
13	Were you told about PACE?	**50%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**19%**	**30%**
15	Could you use a toilet when you needed to?	**96%**	**90%**
16	If you used the toilet, was toilet paper provided?	**33%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**20%**	**32%**
17b	Ventilation/air quality?	**20%**	**22%**
17c	Temperature?	**9%**	**16%**
17d	Lighting?	**31%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**61%**	**55%**
19	Did staff explain the correct use of the cell bell?	**10%**	**22%**
20	Were you held overnight?	**98%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**90%**	**81%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**40%**	**62%**
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?	**85%**	**81%**
25b	Were you offered anything to drink?	**90%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**11%**	**10%**
27	Was the food/drink you received suitable for your dietary requirements?	**44%**	**43%**

Key to tables

		Redbridge Police custody Suites 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?	2%	7%
29	Were you offered anything to read?	8%	13%
30	Was someone informed of your arrest?	45%	42%
31	Were you offered a free telephone call?	54%	49%
If you were denied a free telephone call:			
32	Was a reason given?	12%	14%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	3%	14%
33b	Contacting your partner, relative or friend?	62%	52%
33c	Contacting your employer?	3%	20%
33d	Where you were going once released?	36%	31%
34	Were you offered free legal advice?	88%	88%
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	59%	71%
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	59%	80%
38	Was an appropriate adult present when you were interviewed?	27%	28%
39	Was an interpreter present when you were interviewed?	0%	19%
SECTION 3: Safety			
41	Did you feel unsafe?	55%	39%
42	Has another detainee or a member of staff victimised you?	39%	29%
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	22%	14%
43b	Physical abuse (being hit, kicked or assaulted)	14%	9%
43c	Sexual abuse	2%	4%
43d	Your race or ethnic origin	0%	3%
43e	Drugs	20%	7%
43f	Because of your crime	18%	8%
43g	Because of your sexuality	0%	0%
43h	Because you have a disability	8%	3%
43i	Because of your religion/religious beliefs	4%	2%
43j	Because you are from a different part of the country than others	4%	3%
44	Were your handcuffs removed on arrival at the police station?	76%	72%
45	Were you restrained while in the police custody suite?	21%	19%
46	Were you injured while in police custody, in a way that was not your fault?	21%	23%
47	Were you told how to make a complaint about your treatment?	10%	13%
48	Were you treated well/very well by staff in the police custody suite?	19%	32%

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SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**32%**	**34%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**46%**	**45%**
51b	Nurse	**7%**	**20%**
	Percentage seen by either a doctor or a nurse	**49%**	**51%**
51c	Paramedic	**3%**	**4%**
52	Were you able to see a health care professional of your own gender?	**27%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**33%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**40%**	**36%**
55	Did you have any drug or alcohol problems?	**51%**	**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?	**60%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**29%**	**14%**
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?	**28%**	**32%**
60	Did you have any specific mental health care needs?	**26%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**9%**	**20%**