



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

8–10 May 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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

Ashley House
Monck Street
London SW1P 2BQ
England

# Contents

# 1. Introduction

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

It was clear that significant improvements had been made to the Lewisham custody facility in the recent past. There was a robust governance structure, with dedicated managers and permanent, suitably trained staff and good visibility of senior managers. The borough had sound partnership arrangements but insufficient engagement with the independent custody visitors scheme.

The processes of initial risk assessment and care planning were carried through well. However, there was insufficient control of the suite, especially at pressure times. Detention officers and custody assistants did not work together to the best effect, and we observed avoidable delays in booking in, which led to unnecessary hardship for some detainees. Non-custody staff were allowed free access to the cell area, and detention reviews were not always properly carried out.

Care of detainees was good but there were also shortfalls in the timely availability of interpretation, whether in person or by telephone. Pre-release planning was frequently cursory or absent.

The standard of primary health care and medicines management was good, although some issues of cleanliness and infection control needed to be addressed. There were some gaps and frailties in mental health provision, especially the lack of a mental health inreach service, and staff had not been trained in mental health awareness.

Overall, the custody function in Lewisham was moving in the right direction, and further improvement will depend largely on greater clarity and consistency in the roles played by staff at all levels in the suite itself, together with the specific recommendations set out below. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

**Sir Denis O'Connor**
**HM Chief Inspector of Constabulary**
**June 2012**

**Nick Hardwick**
**HM Chief Inspector of Prisons**

# 2. Background and key findings

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

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

2.3 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.

2.4 This unannounced inspection was conducted at police custody suites in the MPS borough operational command unit (BOCU) of Lewisham. We examined force-wide and BOCU custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites. The main custody suite, located in the centre of Lewisham, had 33 cells and was open 24 hours a day. It had received 4,621 detainees in the previous six months. In the same period, 131 immigration detainees had been held. A further suite was maintained at Catford; this was an MPS resource currently used by the neighbouring borough of Southwark, during refurbishment of the Walworth custody suite in that borough. Accordingly, only the fabric, and not the operations, of the Catford suite have been included in the scope of this report.

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

---

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

[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'.

## Strategy

2.6 The borough commander and senior leadership team (SLT) members gave active strategic and operational leadership. There was a full-time custody manager, and regular meetings at various levels monitored and guided the work of custody. There was good involvement of partners but insufficient active liaison with the independent custody visitors (ICVs). The suite was run under a 25-year private finance initiative (PFI) contract with John Laing Integrated Service Ltd, which also provided custody assistants. It provided sufficient capacity for the borough.

2.7 All staff working in the suite were trained in custody work; the staff team was permanent, with some cover by other trained staff when necessary. Staffing levels were adequate but the respective roles of designated detention officers (DDOs) and custody assistants were too distinct, with the latter doing most of the work for the care and welfare of those detained. Refresher training needed more attention.

2.8 Quality assurance of custody records was thorough but did not include person escort records (PERs) or the checking of closed-circuit television (CCTV) recordings.

## Treatment and conditions

2.9 Staff engaged positively with all detainees, in spite of a lack of privacy in the booking-in process. In general, they showed good awareness of the needs of female detainees, and young people were well looked after. Provision for people with disabilities was not satisfactory but there was reasonable provision for religious needs.

2.10 Risk assessments were carried out thoroughly and reviewed frequently, and care plans were kept up to date as circumstances changed. The nurse was often called upon by staff to give support to individuals. Pre-release risk assessments (PRRAs) were poor. There was no systematic recording of use of force, and use of handcuffs was not always evidently proportionate to risk.

2.11 The cells area was safe and in good condition but the desk area was worn. The response to call bells was mostly prompt and positive but non-custodial officers had unduly free access to the cell area. The custody assistants worked hard to meet detainees' needs but some basic facilities such as exercise and showers were given only on request. The provision of food and drink was good, although the kitchen was dirty.

## Individual rights

2.12 There was no evidence of inappropriate use of detention, although during the inspection one detention review was carried out through the small hatch in a cell door. There was a good appropriate adult (AA) service. There were problems and delays in accessing interpreting services for detainees who did not speak fluent English. UK Border Agency staff were seconded daily to the suite, and solicitors had good access. The virtual court (i.e. by video link) was used effectively but its effect was sometimes to prolong the time spent in police custody.

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

---

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*.)

## Health care

2.14 Nurses employed by the MPS were permanently on site; doctors were on call, with reasonable response times. The medical rooms at both Lewisham and Catford had infection control problems. Stocks of medical supplies were well managed but there were urgent medicines management issues at both suites.

2.15 The quality of assessment and treatment was satisfactory, and there was good liaison between health care and custody staff. Doctors inappropriately took records away from the suite. There was a good substance misuse service, linked effectively to bail restrictions to ensure attendance. There was a lack of confidence in the mental health service, and it was unclear whether procedures for removing those with mental health problems to a place of safety under section 136 of the Mental Health Act 1983[3] were fully appropriate and effective. There was no mental health awareness training for custody staff.

## Main recommendations

2.16 **Custody sergeants should exercise greater control over the suites in order to minimise the number of staff occupying the booking-in area and visiting cells, and to reduce waits for detainees before they are booked in.**

2.17 **Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to mitigate risk when needed.**

## National issues

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

[3] 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.

[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 Criminal Justice Directorate (CJD), led by a commander within territorial policing headquarters. A superintendent was responsible for the day-to-day management of the CJD.

3.2 Responsibility for day-to-day management of Lewisham's custody suite and delivery of services had been devolved to the BOCU. Accountability therefore rested with the BOCU commander, who was a chief superintendent. The Mayor's Office for Policing and Crime (MOPC) had taken over from Metropolitan Police Authority (MPA); however, there was no MOPC lead for custody.

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

3.4 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 Metropolitan Police custody suite. The SOPs covered a broad spectrum of matters, including use of police custody, use of CCTV and guidance to custody staff on the supervision of detainees. They were designed to assist BOCUs to deliver consistent levels of service.

3.5 Strategic leadership of the custody function for the borough of Lewisham was provided by the borough commander. At the senior leadership team (SLT) level, a superintendent *of* operations led the custody function, line-managing a chief inspector of custody and criminal justice. The chief inspector managed a dedicated custody manager and two custody support managers, all of whom were inspectors. Visibility of the SLT in custody was regular, focused and recorded.

3.6 There was one designated full-time custody suite for the borough of Lewisham, located at Lewisham, providing a capacity of 33 cells. The facility was managed under a PFI arrangement with John Laing Integrated Service Ltd. The custody inspector who undertook the custody manager function was full time in this role. The two custody support inspectors provided resilience for the custody inspector. The custody managers line-managed the custody sergeants. There was an additional 12-cell custody facility within the borough at Catford but this was used as a stand-by facility on a MPS-wide basis and was not a borough requirement. The borough was, however, responsible for the maintenance of the facility. At the time of the inspection, Catford custody suite was being used by the borough of Southwark. Only the physical conditions at Catford were examined as part of the inspection.

3.7 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. All of these measures had been put into practice. The register was reviewed monthly by the custody chief inspector, with an escalation process to the SLT.

3.8 Staffing levels in the custody suite were adequate and comprised permanent sergeants, working a nine-hour shift pattern, carrying out custody sergeant duties. The custody sergeants were supported by permanent DDOs. In addition, John Laing provided custody assistants, who were responsible for the ongoing care and welfare of detainees. DDOs undertook booking-in duties, supervised by custody sergeants, although this was not consistent across all shifts. This meant that, generally, DDOs were static at the custody booking-in desk, with most ongoing detainee care and welfare falling to the custody assistants. Line management was not sufficiently rigorous, and there was insufficient direction of DDO and custody assistant resources within the custody facility. Resilience within the staffing of custody units was provided by response sergeants and evidential review sergeants for custody sergeants, and police constable (PC) gaolers for DDOs and custody assistants. There were plans for custody assistants to be trained to book in detainees.

3.9 An SLT member chaired three times daily 'grip and pace' meetings, which were focused mainly on operational priorities but contained standard reference to constant supervision. The custody chief inspector or custody manager attended these meetings, with the opportunity to raise custody issues as necessary. A weekly SLT meeting discussed custody issues by exception and there was informal weekly liaison between the superintendent of operations and the custody chief inspector. The custody chief inspector chaired a bimonthly custody management meeting with the custody managers. ICVs, the CJD and custody nurses also attended this forum. Custody health and safety issues were discussed at the quarterly BOCU health and safety meeting, chaired by the BOCU commander, with successful interventions as a standing item. There was no custody user meeting, and therefore no forum for practitioners to discuss issues.

3.10 There were quality assurance measures in place, and there was evidence of dip-sampling of custody records. This was regular, recorded and auditable but did not incorporate PERs. Dip-sampling of CCTV took place and was recorded. It appropriately focused on the supervision of handovers but was not aligned effectively with custody record dip-sampling.

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 custody chief inspector and CJD. However, the BOCU did not have a central repository for recording successful interventions and communication was dependent on email. Independent Police Complaints Commission (IPCC) 'learning the lessons' information was input on the CJD area on the force intranet, with an expectation from management that staff would regularly visit the site to update themselves. Staff we spoke to were unaware of the 'learning the lessons' document. There was no custody-specific link on the BOCU intranet pages and staff were unclear about the information that they would receive and how to access it.

## Recommendation

3.12 **The Mayor's Office for Policing and Crime should allocate one member as lead for custody.**

## Housekeeping points

3.13 The borough should provide clear direction on the roles and responsibilities of detention officer and custody assistant resources within the custody facility, and monitor this.

3.14 Dip-sampling of custody records should include person escort records and be effectively aligned with dip sampling of CCTV.

3.15 The borough should develop a custody-specific link on the borough operational command unit intranet pages.

## Partnerships

3.16 Partnership arrangements were described as good, with the BOCU commander sitting on the local criminal justice board and the Safer Lewisham Partnership. The BOCU commander also attended a monthly borough forum for criminal justice partners.

3.17 There was an established ICV scheme, and weekly visits were undertaken. ICVs told us that there were sometimes delays in admittance to custody. Police officer attendance at ICV panel meetings was inconsistent and sometimes they did not attend at all. ICVs said that immediate issues were dealt with effectively but that feedback was not always received on outstanding issues. The borough was not sufficiently engaged with the ICV scheme.

## Housekeeping point

3.18 The borough should improve its engagement with the independent custody visitor scheme.

## Learning and development

3.19 All DDOs and custody sergeants performing custody duties had received training before working in custody. Yearly mandatory training was provided, and custody refresher training had recently been provided for staff who had not received such training for more than three years. Custody assistants were trained alongside MPS staff for officer safety training and emergency life-saving training but it was unclear what custody-specific training was provided for the custody assistants although the MPS had provided specifications for this training to the contractor.

## Recommendation

3.20 **Training for custody assistants should be reviewed to ensure that it is fit for purpose and commensurate with the training delivered to others working within custody.**

## Housekeeping point

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

# 4. Treatment and conditions

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

## Respect

4.1 All custody staff interacted with detainees in a professional and respectful manner, and custody sergeants in particular were adept in dealing with detainees who were vulnerable or displayed challenging behaviour. Detainees told us that staff had treated them well throughout their time in the custody suite.

4.2 The booking-in area was spacious but levels of privacy were poor, particularly for detainees who were asked to disclose sensitive or personal information. At busy times, the booking-in area was crowded with police officers and non-custody staff; this contributed to a chaotic atmosphere, and to long waits for detainees on some occasions (see paragraph 4.22).

4.3 Staff demonstrated a reasonable awareness of diversity. Female detainees were given the opportunity to speak to a female officer and asked if they might be pregnant. We observed one detainee who said that she might be pregnant being offered a pregnancy test so that staff could respond accordingly to her needs (for example, obtaining suitable transportation to take her to court). There were no designated cells for female detainees. All detainees were asked about dependency issues during the booking-in process and we observed custody staff offering detainees telephone calls to make arrangements for their children to be cared for while they were detained.

4.4 Five detention rooms were designated for the sole use of juveniles and were located in front of the booking-in desk. Custody sergeants had a good awareness of safeguarding issues that could impact on juveniles or vulnerable adults and had a list of agencies to which they could refer such individuals if they identified any concerns.

4.5 Some staff were aware of the particular needs of transgender detainees when they were being searched.

4.6 Prayer mats, a Qur'an and several Bibles were available. The direction of Mecca was not indicated in any of the cells; one DDO told us that he had identified which direction was east using a compass, so was able to advise detainees, but this was not common knowledge among all custody staff.

4.7 There were no adapted cells for older detainees or those with disabilities. The bed plinths in the cells were low, which made them unsuitable for such detainees. We observed one detainee with his leg in a cast being provided with a chair in his cell. This particular detainee was placed in a CCTV cell, so that custody assistants could provide him with support to get off the bed plinth if necessary. There was a sign indicating that a hearing loop was available in the booking-in area but custody staff told us that they had never seen it.

## Recommendations

4.8 **Booking-in areas should be sufficiently private so that staff and detainees are able to communicate effectively.**

4.9 **Appropriate provision should be made for the physical needs of those with disabilities.**

## Housekeeping points

4.10 The direction of Mecca should be easily identifiable.

4.11 There should be a hearing loop available in the booking-in area and all custody staff should be made aware of how to operate it.

## Safety

4.12 DDOs carried out the initial risk assessment, overseen by a custody sergeant, who authorised detention and decided on observation levels. DDOs asked supplementary questions when detainees divulged that they had harmed themselves in the past or if they were not satisfied with detainees' responses, and this was done sensitively. Initial risk assessments were reasonably comprehensive and contained information which was used to inform care plans. In our custody record analysis, in 12 (40%) records the Police National Computer had been checked for relevant information about risks associated with the detainee. Juveniles and detainees in custody for the first time were automatically placed on 30-minute observations.

4.13 The observation/monitoring levels under which detainees were placed appeared to be appropriate and considered; for example, one detainee was placed on 30-minute observations as he had stated during the risk assessment that he felt 'emotional'. Our custody record analysis showed that risk assessments were monitored and regularly updated, and that observation levels were altered where necessary.

4.14 DDOs understood the type of response they should obtain when conducting rousing checks, and an *aide memoir* of the '4Rs' was posted on each cell door and on the whiteboard in the booking-in area. We observed a chief inspector checking that a custody assistant knew what the '4Rs' were and observing him conducting a rousing check.

4.15 However, many DDOs did not see themselves as gaolers; most did not conduct cell visits or provide custody assistants with support during busy periods. The forthcoming upgrading of custody assistants to DDOs was likely to improve this.

4.16 All cells and communal areas in the custody suite were monitored by CCTV, which included an audio capability. All custody staff carried anti-ligature knives and there were spare knives behind the custody desks.

4.17 The handover arrangements we observed were appropriately conducted. The booking-in area was cleared beforehand and the outgoing custody sergeants discussed the risk assessment, observation levels and any other pertinent information for each detainee with their incoming counterparts. The handovers were video- and audio-recorded and included all staff working in the suite. Following the handover, the incoming custody sergeants visited all the cells, to familiarise and introduce themselves.

4.18 The custody record system in use incorporated a PRRA prompt, to which custody sergeants had to respond before the record could be closed. The quality of PRRAs was poor. Our examination of custody records revealed that, although a PRRA had been completed in 27 (90%) of the records, most simply noted *'no issues'* and were signed. There were no references to how detainees were getting home, including females and young people. All detainees were given a leaflet (Form 61), detailing support services, on their arrival into custody but this was available only in English. Custody staff offered detainees the option of passing on their names to any of the support agencies, and detainees were required to sign a form consenting to this.

## Recommendation

4.19 **All pre-release risk assessments should contain sufficient evidence to support the assessment of risk.**

## Housekeeping point

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

## Use of force

4.21 All staff had been trained in approved safety techniques and received annual refresher training. We were told that if force was used in the custody area, the detainee concerned was normally seen by a health care professional shortly afterwards.

4.22 In our survey, 76% of respondents said that their handcuffs had been removed on arrival at the custody suite, and we observed this to be the case. However, the use of handcuffs at the custody suite was disproportionate. During the inspection, one female detainee was brought to the booking-in desk in handcuffs, despite being described as extremely compliant. During the inspection, of five detainees who waited for up to an hour to be booked in (three of whom had been sent to the custody suite in an error made by central cell allocation), none had their handcuffs removed in the holding area, in spite of the long delay. Furthermore, one of these detainees did not have his handcuffs removed until 15 minutes into the booking-in process.

4.23 Custody staff recorded the use of force in custody records but such data were not collated at a local or force-wide level. The borough was, therefore, not able to analyse use of force in custody to identify trends and the effectiveness of trained use of force techniques.

4.24 Staff told us that the need to strip-search a detainee formed part of the risk assessment process. A total of 262 people, 6% of the total, had been strip-searched during the previous six months.

## Recommendations

4.25 **Detainees should only be handcuffed when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee.**

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

## Physical conditions

4.27 The cells were clean, free of graffiti and had no evident ligature points. Cleaners attended the suite every morning and early evening. Custody staff removed rubbish from cells between uses but did not undertake any cleaning, and cells were put out of use if they were soiled. Toilets, washbasins and showers were clean and tidy. The booking-in area was not well maintained. The floor behind the desk was in a poor state of repair and some notices were affixed to walls using hazard tape, which made it look untidy. The booking-in area was not well lit, as paper had been placed over some of the lights to prevent glare on the computer screens.

4.28 There was a system of daily cell checks, carried out by a custody assistant. This included testing the cell call bells and toilet flush and checking if any prohibited items had been left in the cells. Weekly checks were conducted by the custody manager. All checks were recorded and auditable, with no gaps in the process. Staff told us that any issues identified were rectified promptly, usually within 24 hours, but a cell door that had been broken four days before the inspection had still not been repaired by the end of it. John Laing Integrated Service Ltd also had an inspection regime, which complemented the police checks.

4.29 There was generally good management of cell keys, and they were not given to non-custody staff. However, this did not prevent non-custody staff from having access to detainees. On two occasions we observed non-custody staff entering the custody block. On one of these occasions an investigating officer arrested a detainee through the cell hatch, and on the other an officer asked a custody assistant to open a cell door so that a detainee could sign a document. Both of these incidents occurred without the custody sergeants' approval or knowledge.

4.30 The use of cell call bells was explained to detainees when they were placed in the cell. We saw staff responding promptly to cell call bells, except during a handover, when a call bell was not answered until the handover had been completed.

4.31 There was a fire evacuation policy, which was displayed in the booking-in area. Staff could not recall a fire evacuation drill taking place. The suite was equipped with sufficient sets of rigid handcuffs and other evacuation equipment. Smoking was not allowed in the custody suite.

## Recommendation

4.32 **Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them, and custody sergeants should be informed when officers are going to see detainees in their cells.**

## Housekeeping points

4.33 Cell call bells should be answered promptly at all times.

4.34 Regular fire evacuation drills should be carried out and recorded.

## Detainee care

4.35 All cells contained a mattress and a pillow but they were not routinely wiped down between uses and the mattresses were worn and had lost some of their support. We found stocks of clean blankets but staff told us that they were supplied at night-time and only on request at

other times. All cells had toilets but toilet paper was available only on request. The toilet area was obscured on the CCTV monitors. Hand basins were located in the shower area and detainees were required to ring their cell call bell if they wanted to wash their hands or obtain drinking water.

4.36 Showers were clean but provided little privacy for women. Our custody record analysis showed that only one detainee out of our sample of 30 had had a shower while in custody and another had had a wash before going to court. Two detainees had been held for over 24 hours and had gone to court without taking a shower. Custody staff told us that they would only provide a shower if a detainee requested it but that few detainees did so. Detainees were given paper towels to dry themselves.

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

4.38 There were stocks of replacement clothing, including paper suits, tracksuits and plimsolls, but no replacement underwear. Family and friends could bring in clothing for immigration detainees and those who had been remanded into custody at virtual court (see paragraphs 5.17 and 5.18).

4.39 Our custody record analysis showed that detainees received meals whenever they requested them. In our survey, 88% of respondents, in line with the comparator, said that they had been offered something to eat. Detainees were provided with hot and cold meals from the police canteen during its opening hours, 7am to 7pm. Outside of these hours there was a good stock of microwave meals, including halal and vegetarian options. We observed drinks being offered regularly.

4.40 There was an indoor exercise yard which had some access to the fresh air. It contained seats, was monitored by CCTV and had a panic alarm, and custody staff told us that they stayed with detainees who were out in the yard. Not all detainees we spoke to were aware that they could have time in the fresh air. In our custody record analysis, no detainees in our sample had taken exercise, although one detainee had been placed in handcuffs and taken out of the station for a cigarette, as he had become agitated and it had been felt that this would calm him down.

4.41 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, four detainees had been offered reading materials. Visits to detainees from family members were not encouraged due to the lack of visiting facilities.

## Recommendations

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

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

## Housekeeping points

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

4.45 Toilet paper should be routinely provided in each cell and feminine hygiene products should be routinely offered to female detainees.

4.46 Replacement underwear should be available at all suites.

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

4.48 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 We observed custody sergeants checking the circumstances of the offence and arrest to determine if detention was appropriate. Most custody sergeants could recall only a few occasions when they had refused to detain. However, we witnessed a sergeant providing telephone advice in one case, explaining the grounds for detention that were needed before the individual would be accepted as a detainee. Staff were not aware of any restorative justice programmes but told us that the use of voluntary attendance ('Caution +3') as an alternative to detention had recently increased.

5.2 Custody sergeants were clear about their obligations to ensure that cases proceeded quickly. We were told, and observed, that investigating staff sometimes required prompting to ensure that there were no unnecessary delays. In our custody record analysis, seven (23%) detainees had been held for more than 24 hours and 14 (47%) had been held overnight, including those who had arrived between midnight and 3am and had not been released until the morning. Only nine (30%) detainees in our sample had been held for less than six hours.

5.3 Data supplied by the force showed that in the previous six months, 131 immigration detainees had been held at Lewisham, with an average detention time of 13 hours 32 minutes. Custody staff reported excellent relationships with the UK Border Agency (UKBA), which they attributed to the secondment of two immigration officers, based at the police station. These members of staff provided cover between 7am and 7pm, from Monday to Friday, and we observed one to be very active in the custody suite. These working practices allowed UKBA to gain first-hand knowledge of individuals, trends and demographics. However, staff reported delays in immigration detainees being picked up by the escort contractor for onward transportation to placements in the immigration custody estate.

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.[5]

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 2.18). Family members or family friends were usually contacted in the first instance to act as an AA and we observed this occurring on several occasions. In one case where a family member attended the custody suite to act as an AA for his vulnerable brother, we witnessed the custody sergeant provide the individual with clear direction, thoroughly detailing the parameters of the role of an AA. When family members or friends were not available, there was an effective volunteer service (Catch 22), which covered Lewisham and two neighbouring boroughs, operating between 9am and midnight, Monday to Friday, and catering for juveniles and vulnerable adults alike. Outside these hours, staff had to request AAs from social services and we were told that this involved long delays.

[5] 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.

5.6 In our custody record sample, there were three young people aged under 17. One had been held for 17 hours, and the other two for four and 10 hours, respectively. It was clear in only one record that an AA had been present when the detainee had been given his rights and interviewed. However, one of the remaining two records noted that the detainee had spoken to an AA, and the other that the detainee's father had been present at the police station. Four of the older detainees in our analysis had reported mental health problems. An AA had been called for one of them and had been present for the reading of his rights; the individual had not been interviewed.

5.7 During booking-in, staff provided all detainees with a leaflet summarising their rights and entitlements. These could be downloaded and printed for a non-English-speaking detainee in their own language but none was available in a pictorial or easy-read format for detainees with learning difficulties or limited literacy. In our custody record analysis, there were nine (30%) foreign nationals in the sample; seven of whom had been given a copy of their foreign national rights. One of these detainees had been too intoxicated on arrival to be given his rights and there was no record that these had been given once he had sobered up.

5.8 A professional telephone interpreting service, used with two-handset telephones, was available at two of the booking-in desks and in the health care room. We witnessed staff having difficulties when attempting to access telephone interpreting services on behalf of two detainees (Bulgarian and Algerian Berber) due to the lack of availability of interpreting staff fluent in the required languages. This resulted in a face-to-face interpreter being immediately requested in one case, to attend to carry out the initial rights procedure. When interpreting services had been required later in the day, to interview this detainee, difficulties were experienced in obtaining a face-to-face service, which resulted in the detainee becoming very agitated. DDOs took the initiative to use 'Google Translate' to advise the detainee what had been arranged, why there was a delay and also provide a projected timescale, which helped to alleviate some of his anxiety.

5.9 Custody sergeants told us that they often contacted social services for secure accommodation beds, to prevent juveniles from being held in police custody overnight, but were always refused. They did not consider the use of non-secure beds for vulnerable juveniles who did not require secure accommodation but somewhere safe to stay.

## Recommendations

5.10 **Lewisham police should further develop and promote alternative-to-custody approaches.**

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

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

## Rights relating to PACE

5.13 Detainees' right to free legal representation was clearly explained to them. Those who refused the offer were asked the reasons why; these were recorded in the custody record and such detainees were reminded that they could change their mind at any time. In our custody record analysis, 19 (63%) detainees had accepted the offer of legal advice, and one further detainee

later changed their mind. Of the 11 detainees who had declined the offer of legal advice, the reason for declining had been noted in only seven records. All such detainees had been reminded of their right to free legal advice.

5.14 A duty solicitor scheme was in place. Posters indicating this, in 23 different languages, were displayed prominently in the custody suite. The custody suite had two consultation rooms and a number of clean, well-equipped interview rooms. Solicitors we spoke to told us that custody staff were helpful and facilitative. We saw a solicitor receiving a copy of her detainee's custody record on request. Detainees were told that they could consult the PACE codes of practice. There was only one copy of the PACE codes of practice available in the suite but we were told that an order for additional copies had been submitted. Detainees were not interviewed while under the influence of drugs or alcohol.

5.15 On booking-in, detainees were told that they could inform someone of their arrest. In our custody record analysis, nine (30%) detainees asked for someone to be informed of their arrest. In only five of these cases was there evidence that custody staff had made attempts to contact the nominated person. In addition, six (20%) detainees had made a telephone call during their time in custody.

5.16 Our custody record analysis showed that reviews of detention were, in most cases, held in line with statutory requirements and time frames. However, in one case the inspector's review had taken place after 3.5 hours and it was not clear why this had occurred. We also observed one inspector's review being conducted through the hatch of a cell door, which was not appropriate in the circumstances.

5.17 Staff in the custody suite were responsible for populating the booking system for a virtual court operated by Bromley Magistrates' Court. This was used by the boroughs of Plumstead, Bromley and Bexleyheath, in addition to Lewisham, with each custody suite being able to request up to a maximum allocation of six time slots on any court day. The virtual court operated within a number of eligibility and suitability criteria; for example, arrests on warrant, breach of bail or breach of peace were not eligible, and cases involving defendants with mental health issues, presenting a risk of violence or under 18 years of age, or involving more than two co-defendants, were not suitable.

5.18 We observed the operation of the virtual court and found it to be professional, with one case being adjourned to allow the detainee to consult a solicitor after changing his mind about not being legally represented. An unintended consequence of the virtual court was the increase in the length of time that detainees were held in police custody and the impact that this could have on police resources. We were told of numerous delays resulting from the person escort contractor (Serco) failing to pick up remanded and sentenced prisoners, which meant that detainees were regularly held overnight or even longer before being moved on to the prison estate. When coupled with the need for the increased levels of observation required during these extended detentions, including staffing constant watches, such practices had implications for police resources.

5.19 There was an effective process for the prompt collection of DNA samples at Lewisham. However, the DNA samples we saw at Catford were several weeks old.

5.20 Arrangements for getting detainees to court on time were mostly efficient. We were told by a sergeant that in the previous two weeks, arrangements had to be made for police to convey a juvenile to court, as the prisoner escort contractor had not been able to take him because there were already adults on board their vehicle. We observed prisoner escort staff arriving to convey three juvenile detainees, one female and two males, to court. These detainees were all

placed on the same vehicle, with no screening in place, despite it being fitted, to screen the female from the view of the males. This female had been on constant supervision overnight due to self-harming issues. Court cut-off times at Bromley were reasonable, at approximately 3pm on weekdays.

## Housekeeping points

5.21 A sufficient number of copies of the PACE codes of practice should be made available.

5.22 Face-to-face inspector reviews of detention under the PACE codes of practice should be conducted in a professional and appropriate manner.

5.23 The Borough should have in place a structured process for the regular and timely collection of forensic samples and there should be management oversight of this

## Rights relating to treatment

5.24 Detainees 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. Although there was a clear expectation from the BOCU that complaints from detainees would be taken 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, but most said that they would advise the detainee to attend at the front desk on release. The borough received information about complaints but there was no breakdown of those which related to custody, so there was no analysis of trends and themes.

## 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. The force should monitor and analyse trends in complaints, and take corrective action where necessary.**

# 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 Nurses employed by the MPS provided the service. Our survey indicated that 54% of detainees had used the health services in police custody. Mental health services were provided by the South London and Maudsley Mental Health NHS Foundation Trust (SLAM) and substance misuse services were provided by Penrose Fusion, an independent sector provider. Police inspectors managed the strategic approach to mental health and substance misuse services, and monitored the substance use services contract.

6.2 Clinical and substance misuse staff were respectful to detainees. They had access to interpreting services if required. In our survey, only 17% of detainees seen by a health professional rated the quality of care as good or very good, although detainees we spoke to raised no issues about health care and there had been no complaints about health care in the previous 12 months.

6.3 Clinical governance arrangements for nurses were NHS-compatible, with the exception that they had no regular access to clinical supervision. Plans were being formulated to introduce this in the near future.

6.4 There were clinical rooms at Lewisham and Catford. The clinical room at Catford was not fit for purpose, having substantially substandard infection control practices. At Lewisham, there were some minor infection control issues – for example, non-offset sink drains and a lack of hand-washing instructions. Generally, the room was of a reasonable size, fit for purpose and clean, although cleaning above head height was problematic; steps had been taken to address this issue. Good attention was paid to the privacy and confidentiality of detainees during consultations, with the doors being closed, although a privacy screen was not available. Sharps boxes were secured to the walls and were correctly labelled. The clinical room contained medical equipment and supplies that were in date, and overall stock control was good. The health care and substance use rooms were not used by custody staff and were locked when not in use. There were no patient information leaflets in the clinical room (although there were in the substance use room) and no health screening or promotion materials on display.

6.5 Emergency equipment was available in the custody suites and included a first-aid kit, resuscitation equipment and automated external defibrillators, which were easily accessible. The kit was regularly checked but was grubby. The custody staff we spoke to were up to date with their first-aid and resuscitation training.

## Recommendations

6.6 **All clinical rooms should be fit for purpose and should be subject to an infection control audit.**

6.7 **If it is clinically indicated, methadone should be available to detainees, in line with national guidelines.**

## Housekeeping points

6.8 Privacy screens should be provided in the consultation rooms.

6.9 Patient information leaflets should be accessible in the clinical rooms.

6.10 The refrigerators for the storage of heat-sensitive clinical products in the clinical rooms should have their maximum and minimum temperatures recorded daily, to ensure that such items are stored within the 2–8°C range**.**

6.11 All used and out-of-date clinical and medical stock should be disposed of and regular checks of expiry dates instigated.

6.12 Out-of-date pharmacological reference materials should be discarded and replaced by up-to-date materials.

## Patient care

6.13 Nurses were available on site 24 hours a day. Custody staff expressed high satisfaction with the service. Detainees were attended to by nurses very quickly. When forensic medical examiners were required, they responded in less than an hour.

6.14 New arrivals were asked if they wanted to see a health care professional, or custody officers referred them to one if they presented any health-related concerns. Nurses visited cells to see if anyone required assistance and our analysis of custody records indicated that one in five (20%) detainees were seen. Assessment and treatment appeared appropriate. Clinical records were stored in line with the Data Protection Act and used following Caldicott principles.[6] Custody staff expressed satisfaction with medical guidance placed on the national strategy for police information systems (NSPIS).

6.15 Medicines management was good, except for an historical artefact (an anomalous medication cabinet; see below), which presented a risk. Nurses used patient group directions to provide an appropriate range of medications. Stock was in date and cupboards were tidy and regularly checked. Nurses dispensed and disposed of surplus medications. The stock of divertible medications was counted at each shift. There was a refrigerator for the storage of heat-sensitive products but it did not have temperature sensors and there were no records of checks. There was an additional and anomalous medication cabinet in the clinical room which was not used by contemporary staff. This contained a substantial stock of out-of-date medications and appeared not to be managed by anyone. When we raised the issue, the nurse manager received authorisation to dispose of the stock, and did so. Some pharmacy reference materials were out of date.

6.16 In our survey, of detainees previously on medications, 23% had been able to continue it while in custody. Custody staff made attempts to retrieve medications from detainees' homes if necessary. There was no programme of supervised consumption of methadone. Symptomatic relief was prescribed for those withdrawing from substances.

[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

6.17 In our survey, 50% of respondents said that they had a drug or alcohol problem. Our analysis of custody records indicated that 27% of detainees were intoxicated when brought into custody and, in our survey, 64% said that they had been offered an opportunity to see a drug worker, against a comparator of 42%. There were good multi-agency working arrangements to ensure that substance users could readily access the relevant services for their need.

6.18 Penrose Fusion staff provided an intensive drug intervention programme from 7.30am to 10.30pm, six days a week. Drug workers were based at the Lewisham custody suite. In addition to seeing those who tested positive for drugs, they visited every cell to ask detainees if they wanted assistance. Out of hours, custody staff called the helpline to make appointments for detainees. The use of restrictions on bail was said to be proving effective in managing offenders with substance misuse problems. Substance use services were offered to adults aged 18 or above. In our survey, 27% of detainees with drug or alcohol problems said that they had been offered symptomatic relief while in custody. Detainees whose problems related to alcohol were offered advice in accessing appropriate services, and juveniles were signposted to services for young people. Substance users were offered an extensive variety of programmes following release and detainees who needed it were signposted to needle exchange services in the community.

## Mental health

6.19 In our survey, 17% of detainees said that they had mental health problems. Partnership working between the police and SLAM was generally good but some custody staff were unaware of the formal meetings structure. There was no mental health inreach service, although the nurses liaised with SLAM, on behalf of the police, when Mental Health Act opinions were thought to be required. There was a revised (December 2011) joint operational policy for the use of section 136 but custody staff were not aware of its existence. The NHS section 136 suite was at nearby Ladywell Hospital. On average, police custody had been used as a place of safety for just over one detainee per week in the previous two years for the purposes of section 136. Health services staff said that most detainees taken to the section 136 suite were subsequently detained under the Mental Health Act or agreed to stay on a voluntary basis, suggesting that section 136 was being used appropriately by the police. Regular mental health training for custody staff had been withdrawn over a year earlier, to enable updating of the programme, but it had not been reintroduced.

## Recommendations

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

6.21 **Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems, and work effectively with health staff to ensure a detainee's care.**

# 7. Summary of recommendations

## Main recommendations

7.1 Custody sergeants should exercise greater control over the suites in order to minimise the number of staff occupying the booking-in area and visiting cells, and to reduce waits for detainees before they are booked in. (2.16)

7.2 Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to mitigate risk when needed. (2.17)

## National issues

7.3 Appropriate adults should be available to support juveniles aged 17 in custody, including out of hours, without undue delay. (2.18)

## Recommendations

### Strategy

7.4 The Mayor's Office for Policing and Crime should allocate one member as lead for custody. (3.12)

7.5 Training for custody assistants should be reviewed to ensure that it is fit for purpose and commensurate with the training delivered to others working within custody. (3.20)

### Treatment and conditions

7.6 Booking-in areas should be sufficiently private so that staff and detainees are able to communicate effectively. (4.8)

7.7 Appropriate provision should be made for the physical needs of those with disabilities. (4.9)

7.8 All pre-release risk assessments should contain sufficient evidence to support the assessment of risk. (4.19)

7.9 Detainees should only be handcuffed when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee. (4.25)

7.10 The Metropolitan Police Service should collate use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.26)

7.11 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them, and custody sergeants should be informed when officers are going to see detainees in their cells. (4.32)

7.12 All detainees held overnight, or who require one, should be offered a shower and be provided with a cotton towel. (4.42)

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

### Individual rights

7.14 Lewisham police should further develop and promote alternative-to-custody approaches. (5.10)

7.15 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.11)

7.16 The Metropolitan Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.12)

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. The force should monitor and analyse trends in complaints, and take corrective action where necessary. (5.25)

### Health care

7.18 All clinical rooms should be fit for purpose and should be subject to an infection control audit. (6.6)

7.19 If it is clinically indicated, methadone should be available to detainees, in line with national guidelines. (6.7)

7.20 There should be a mental health diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services. (6.20)

7.21 Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems, and work effectively with health staff to ensure a detainee's care. (6.21)

## Housekeeping points

### Strategy

7.22 The borough should provide clear direction on the roles and responsibilities of detention officer and custody assistant resources within the custody facility, and monitor this. (3.13)

7.23 Dip-sampling of custody records should include person escort records and be effectively aligned with dip sampling of CCTV. (3.14)

7.24 The borough should develop a custody-specific link on the borough operational command unit intranet pages. (3.15)

7.25 The borough should improve its engagement with the independent custody visitor scheme. (3.18)

7.26 There should be management oversight of refresher training, to ensure that all staff working in custody receive regular refresher training at least annually. (3.21)

## Treatment and conditions

7.27 The direction of Mecca should be easily identifiable. (4.10)

7.28 There should be a hearing loop available in the booking-in area and all custody staff should be made aware of how to operate it. (4.11)

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

7.30 Cell call bells should be answered promptly at all times. (4.33)

7.31 Regular fire evacuation drills should be carried out and recorded. (4.34)

7.32 Blankets should be provided routinely and mattresses should always be wiped down between uses. (4.44)

7.33 Toilet paper should be routinely provided in each cell and feminine hygiene products should be routinely offered to female detainees. (4.45)

7.34 Replacement underwear should be available at all suites. (4.46)

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

7.36 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods. (4.48)

## Individual rights

7.37 A sufficient number of copies of the PACE codes of practice should be made available. (5.21)

7.38 Face-to-face inspector reviews of detention under the PACE codes of practice should be conducted in a professional and appropriate manner. (5.22)

7.39 The Borough should have in place a structured process for the regular and timely collection of forensic samples and there should be management oversight of this process. (5.23)

## Health care

7.40 Privacy screens should be provided in the consultation rooms. (6.8)

7.41 Patient information leaflets should be accessible in the clinical rooms. (6.9)

7.42 The refrigerators for the storage of heat-sensitive clinical products in the clinical rooms should have their maximum and minimum temperatures recorded daily, to ensure that such items are stored within the 2–8°C range. (6.10)

7.43 All used and out-of-date clinical and medical stock should be disposed of and regular checks of expiry dates instigated. (6.11)

7.44 Out-of-date pharmacological reference materials should be discarded and replaced by up-to-date materials. (6.12)

# Appendix I: Inspection team

| | |
|---|---|
| Martin Kettle | HMIP team leader |
| Paul Davies | HMIC inspector |
| Mark Ewan | HMIC inspector |
| Fiona Shearlaw | HMIP inspector |
| Vinnett Pearcy | HMIP inspector |
| Paul Tarbuck | HMIP health care inspector |
| Susan Walker | CQC inspector |
| Hayley Cripps | HMIP research officer |
| Rachel Murray | HMIP research officer |

# 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 Lewisham, 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 30 April 2012 at HMP High Down and 1 May 2012 at HMP Belmarsh. A list of potential respondents to have passed through Lewisham or Catford police stations was created, listing all those who had arrived from Bromley or Greenwich Magistrates' Court within the previous two months.[7]

### Selecting the sample

In total, 121 respondents were approached. Seventy-one respondents reported being held in police stations outside of Lewisham. On the day, the questionnaire was offered to 50 respondents; there were two refusals and three non-returns. All of those sampled had been in custody within the previous three months.

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

### 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, 45 (90%) respondents completed and returned their questionnaires.

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

## Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 54 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?**
Lewisham 43; Catford 2

**Q3 How old are you?**

| | | | |
|---|---|---|---|
| *16 years or younger* | 1 (2%) | *40-49 years* | 8 (18%) |
| *17-21 years* | 6 (13%) | *50-59 years* | 1 (2%) |
| *22-29 years* | 14 (31%) | *60 years or older* | 0 (0%) |
| *30-39 years* | 15 (33%) | | |

**Q4 Are you:**

| | |
|---|---|
| *Male* | 45 (100%) |
| *Female* | 0 (0%) |
| *Transgender/transsexual* | 0 (0%) |

**Q5 What is your ethnic origin?**

| | |
|---|---|
| *White - British* | 16 (36%) |
| *White - Irish* | 1 (2%) |
| *White - other* | 4 (9%) |
| *Black or black British - Caribbean* | 12 (27%) |
| *Black or black British - African* | 4 (9%) |
| *Black or black British - other* | 2 (4%) |
| *Asian or Asian British - Indian* | 1 (2%) |
| *Asian or Asian British - Pakistani* | 1 (2%) |
| *Asian or Asian British - Bangladeshi* | 0 (0%) |
| *Asian or Asian British - other* | 0 (0%) |
| *Mixed heritage - white and black Caribbean* | 2 (4%) |
| *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* | 2 (4%) |

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

| | |
|---|---|
| *Yes* | 9 (23%) |
| *No* | 31 (78%) |

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

| | |
|---|---|
| ***None*** | 8 (19%) |
| *Church of England* | 16 (37%) |
| *Catholic* | 8 (19%) |
| *Protestant* | 0 (0%) |

*Other Christian denomination* ..... 4 (9%)
*Buddhist* ..... 0 (0%)
*Hindu* ..... 0 (0%)
*Jewish* ..... 0 (0%)
*Muslim* ..... 7 (16%)
*Sikh* ..... 0 (0%)

**Q8 How would you describe your sexual orientation?**
*Straight/heterosexual* ..... 41 (98%)
*Gay/lesbian/homosexual* ..... 1 (2%)
*Bisexual* ..... 0 (0%)

**Q9 Do you consider yourself to have a disability?**
*Yes* ..... 10 (23%)
*No* ..... 34 (77%)

**Q10 Have you ever been held in police custody before?**
*Yes* ..... 40 (91%)
*No* ..... 4 (9%)

## Section 2: Your experience of the police custody suite

**Q11 How long were you held at the police station?**
*Less than 24 hours* ..... 8 (18%)
*More than 24 hours, but less than 48 hours (2 days)* ..... 21 (47%)
*More than 48 hours (2 days), but less than 72 hours (3 days)* ..... 10 (22%)
*72 hours (3 days) or more* ..... 6 (13%)

**Q12 Were you told your rights when you first arrived there?**
*Yes* ..... 32 (71%)
*No* ..... 8 (18%)
*Don't know/can't remember* ..... 5 (11%)

**Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**
*Yes* ..... 19 (42%)
*No* ..... 15 (33%)
*I don't know what this is/I don't remember* ..... 11 (24%)

**Q14 If your clothes were taken away, what were you offered instead?**
***My clothes were not taken*** ..... 22 (51%)
*I was offered a tracksuit to wear* ..... 12 (28%)
*I was offered an evidence/paper suit to wear* ..... 2 (5%)
*I was **only** offered a blanket* ..... 3 (7%)
*Nothing* ..... 4 (9%)

**Q15 Could you use a toilet when you needed to?**
*Yes* ..... 39 (87%)
*No* ..... 6 (13%)
*Don't know* ..... 0 (0%)

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

| | |
|---|---|
| *Yes* | 16 (36%) |
| *No* | 28 (64%) |

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

| | *Good* | *Neither* | *Bad* |
|---|---|---|---|
| Cleanliness | 20 (44%) | 8 (18%) | 17 (38%) |
| Ventilation/air quality | 11 (26%) | 7 (17%) | 24 (57%) |
| Temperature | 6 (14%) | 4 (9%) | 33 (77%) |
| Lighting | 18 (42%) | 6 (14%) | 19 (44%) |

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

| | |
|---|---|
| *Yes* | 20 (47%) |
| *No* | 23 (53%) |

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

| | |
|---|---|
| *Yes* | 7 (16%) |
| *No* | 38 (84%) |

**Q20** **Were you held overnight?**

| | |
|---|---|
| *Yes* | 42 (93%) |
| *No* | 3 (7%) |

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

| | |
|---|---|
| ***Not held overnight*** | 3 (7%) |
| *Pillow* | 23 (51%) |
| *Blanket* | 29 (64%) |
| *Nothing* | 10 (22%) |

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

| | |
|---|---|
| ***Not held overnight/did not get any bedding*** | 13 (32%) |
| *Yes* | 17 (41%) |
| *No* | 11 (27%) |

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

| | |
|---|---|
| *Yes* | 3 (7%) |
| *No* | 42 (93%) |

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

| | |
|---|---|
| *Yes* | 2 (4%) |
| *No* | 43 (96%) |

**Q25** **Were you offered anything to:**

| | *Yes* | *No* |
|---|---|---|
| Eat? | 38 (88%) | 5 (12%) |
| Drink? | 34 (79%) | 9 (21%) |

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

| *Very good* | *Good* | *Neither* | *Bad* | *Very bad* | *N/A* |
|---|---|---|---|---|---|
| 1 (2%) | 6 (14%) | 6 (14%) | 12 (28%) | 12 (28%) | 6 (14%) |

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

| | |
|---|---|
| ***I did not have any food or drink*** | 6 (15%) |
| *Yes* | 15 (37%) |
| *No* | 20 (49%) |

**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 (9%) |
| *I was allowed to smoke* | 2 (5%) |
| *I was offered a nicotine substitute* | 0 (0%) |
| *I was not offered anything to cope with not smoking* | 37 (86%) |

**Q29 Were you offered anything to read?**

| | |
|---|---|
| *Yes* | 4 (9%) |
| *No* | 40 (91%) |

**Q30 Was someone informed of your arrest?**

| | |
|---|---|
| *Yes* | 17 (39%) |
| *No* | 21 (48%) |
| *I don't know* | 2 (5%) |
| *I didn't want to inform anyone* | 4 (9%) |

**Q31 Were you offered a free telephone call?**

| | |
|---|---|
| *Yes* | 21 (49%) |
| *No* | 22 (51%) |

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

| | |
|---|---|
| ***My telephone call was not denied*** | 23 (55%) |
| *Yes* | 5 (12%) |
| *No* | 14 (33%) |

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

| | *Yes* | *No* |
|---|---|---|
| Who was taking care of your children | 8 (24%) | 26 (76%) |
| Contacting your partner, relative or friend | 23 (59%) | 16 (41%) |
| Contacting your employer | 11 (31%) | 24 (69%) |
| Where you were going once released | 19 (53%) | 17 (47%) |

**Q34 Were you offered free legal advice?**

| | |
|---|---|
| *Yes* | 37 (84%) |
| *No* | 7 (16%) |

**Q35 Did you accept the offer of free legal advice?**

| | |
|---|---|
| ***Was not offered free legal advice*** | 7 (16%) |
| *Yes* | 22 (51%) |
| *No* | 14 (33%) |

**Q36 Were you interviewed by police about your case?**

| | |
|---|---|
| *Yes* | 40 (91%) |
| *No* | 4 (9%) |

**Q37 Was a solicitor present when you were interviewed?**

| | |
|---|---|
| ***Did not ask for a solicitor/was not interviewed*** | 6 (14%) |
| *Yes* | 27 (61%) |
| *No* | 11 (25%) |

**Q38 Was an appropriate adult present when you were interviewed?**

| | |
|---|---|
| ***Did not need an appropriate adult/was not interviewed*** | 25 (63%) |
| *Yes* | 5 (13%) |
| *No* | 10 (25%) |

**Q39 Was an interpreter present when you were interviewed?**

| | |
|---|---|
| ***Did not need an interpreter/was not interviewed*** | 26 (65%) |
| *Yes* | 2 (5%) |
| *No* | 12 (30%) |

## Section 3: Safety

**Q41 Did you feel safe there?**

| | |
|---|---|
| *Yes* | 21 (49%) |
| *No* | 22 (51%) |

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

| | |
|---|---|
| *Yes* | 17 (40%) |
| *No* | 26 (60%) |

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

| | | | |
|---|---|---|---|
| ***I have not been victimised*** | 26 (62%) | *Because of your crime* | 6 (14%) |
| *Insulting remarks (about you, your family or friends)* | 6 (14%) | *Because of your sexuality* | 0 (0%) |
| *Physical abuse (being hit, kicked or assaulted)* | 4 (10%) | *Because you have a disability* | 1 (2%) |
| *Sexual abuse* | 0 (0%) | *Because of your religion/religious beliefs* | 1 (2%) |
| *Your race or ethnic origin* | 3 (7%) | *Because you are from a different part of the country than others* | 3 (7%) |
| *Drugs* | 5 (12%) | | |

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

| | |
|---|---|
| *Yes* | 31 (70%) |
| *No* | 10 (23%) |
| *I wasn't handcuffed* | 3 (7%) |

**Q45 Were you restrained whilst in the police custody suite?**

| | |
|---|---|
| *Yes* | 11 (26%) |
| *No* | 32 (74%) |

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

| | |
|---|---|
| *Yes* | 13 (31%) |
| *No* | 29 (69%) |

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

| | |
|---|---|
| *Yes* | 3 (7%) |
| *No* | 41 (93%) |

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

| *Very well* | *Well* | *Neither* | *Badly* | *Very badly* | *Don't remember* |
|---|---|---|---|---|---|
| 1 (2%) | 13 (31%) | 14 (33%) | 6 (14%) | 8 (19%) | 0 (0%) |

## Section 4: Health care

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

| | |
|---|---|
| *Yes* | 19 (43%) |
| *No* | 23 (52%) |
| *Don't know* | 2 (5%) |

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

| | *Yes* | *No* |
|---|---|---|
| Doctor | 10 (29%) | 24 (71%) |
| Nurse | 16 (43%) | 21 (57%) |
| Paramedic | 1 (4%) | 27 (96%) |

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

| | |
|---|---|
| *Yes* | 7 (29%) |
| *No* | 15 (63%) |
| *Don't know* | 2 (8%) |

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

| | |
|---|---|
| *Yes* | 12 (28%) |
| *No* | 31 (72%) |

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

| | |
|---|---|
| ***Not taking medication*** | 31 (72%) |
| *Yes* | 3 (7%) |
| *No* | 9 (21%) |

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

| | |
|---|---|
| *Yes* | 22 (50%) |
| *No* | 22 (50%) |

**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*** | 22 (50%) |
| *Yes* | 14 (32%) |
| *No* | 8 (18%) |

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

| | |
|---|---|
| ***I didn't have any drug/alcohol problems*** | 22 (54%) |
| *Yes* | 5 (12%) |
| *No* | 14 (34%) |

**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* |
|---|---|---|---|---|---|
| 19 (48%) | 2 (5%) | 2 (5%) | 13 (33%) | 0 (0%) | 4 (10%) |

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

| | |
|---|---|
| *Yes* | 15 (37%) |
| *No* | 26 (63%) |

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

| | |
|---|---|
| *Yes* | 7 (16%) |
| *No* | 36 (84%) |

**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*** | 36 (84%) |
| *Yes* | 0 (0%) |
| *No* | 7 (16%) |

# Prisoner survey responses for Lewisham police 2012

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

**Key to tables**

| | | 2012 Lewisham | 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** | | 45 | 1988 |
| **SECTION 1: General information** | | | |
| **3** | Are you under 21 years of age? | **16%** | **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)? | **54%** | **29%** |
| **6** | Are you a foreign national? | **23%** | **14%** |
| **7** | Are you Muslim? | **17%** | **10%** |
| **8** | Are you homosexual/gay or bisexual? | **2%** | **2%** |
| **9** | Do you consider yourself to have a disability? | **22%** | **20%** |
| **10** | Have you been in police custody before? | **92%** | **92%** |
| **SECTION 2: Your experience of this custody suite** | | | |
| **11** | Were you held at the police station for over 24 hours? | **82%** | **68%** |
| **12** | Were you told your rights when you first arrived? | **72%** | **82%** |
| **13** | Were you told about PACE? | **42%** | **52%** |
| For those who had their clothing taken away: | | | |
| **14** | Were you given a tracksuit to wear? | **57%** | **38%** |
| **15** | Could you use a toilet when you needed to? | **86%** | **91%** |
| **16** | If you used the toilet, was toilet paper provided? | **37%** | **47%** |
| **17** | Would you rate the condition of your cell, as 'good' for: | | |
| **17a** | Cleanliness? | **44%** | **33%** |
| **17b** | Ventilation/air quality? | **26%** | **23%** |
| **17c** | Temperature? | **15%** | **16%** |
| **17d** | Lighting? | **42%** | **45%** |
| **18** | Was there any graffiti in your cell when you arrived? | **46%** | **54%** |
| **19** | Did staff explain the correct use of the cell bell? | **16%** | **23%** |
| **20** | Were you held overnight? | **94%** | **92%** |
| For those who were held overnight: | | | |
| **21** | Were you given any items of bedding? | **77%** | **85%** |
| For those who were held overnight and were given items of bedding: | | | |
| **22** | Were these clean? | **61%** | **62%** |
| **23** | Were you offered a shower? | **6%** | **9%** |
| **24** | Were you offered a period of outside exercise? | **4%** | **6%** |
| **25a** | Were you offered anything to eat? | **88%** | **81%** |
| **25b** | Were you offered anything to drink? | **79%** | **84%** |
| For those who had food/drink: | | | |
| **26** | Was the quality of the food and drink you received good/very good? | **20%** | **11%** |
| **27** | Was the food/drink you received suitable for your dietary requirements? | **44%** | **44%** |

**Key to tables**

| | | 2012 Lewisham | 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? | **4%** | **7%** |
| **29** | Were you offered anything to read? | **8%** | **13%** |
| **30** | Was someone informed of your arrest? | **39%** | **43%** |
| **31** | Were you offered a free telephone call? | **49%** | **49%** |
| If you were denied a free telephone call: | | | |
| **32** | Was a reason given? | **27%** | **14%** |
| **33** | Did you have any concerns about: | | |
| **33a** | Who was taking care of your children? | **24%** | **14%** |
| **33b** | Contacting your partner, relative or friend? | **59%** | **52%** |
| **33c** | Contacting your employer? | **31%** | **19%** |
| **33d** | Where you were going once released? | **53%** | **31%** |
| **34** | Were you offered free legal advice? | **84%** | **89%** |
| For those who were offered free legal advice: | | | |
| **35** | Did you accept the offer of free legal advice? | **60%** | **71%** |
| For those who were were interviewed and needed them: | | | |
| **37** | Was a solicitor present when you were interviewed? | **71%** | **79%** |
| **38** | Was an appropriate adult present when you were interviewed? | **35%** | **27%** |
| **39** | Was an interpreter present when you were interviewed? | **13%** | **14%** |
| **SECTION 3: Safety** | | | |
| **41** | Did you feel unsafe? | **51%** | **38%** |
| **42** | Has another detainee or a member of staff victimised you? | **40%** | **32%** |
| **43** | If you have felt victimised, what did the incident involve? | | |
| **43a** | Insulting remarks (about you, your family or friends) | **15%** | **15%** |
| **43b** | Physical abuse (being hit, kicked or assaulted) | **9%** | **10%** |
| **43c** | Sexual abuse | **0%** | **3%** |
| **43d** | Your race or ethnic origin | **7%** | **2%** |
| **43e** | Drugs | **13%** | **9%** |
| **43f** | Because of your crime | **15%** | **11%** |
| **43g** | Because of your sexuality | **0%** | **1%** |
| **43h** | Because you have a disability | **2%** | **2%** |
| **43i** | Because of your religion/religious beliefs | **2%** | **2%** |
| **43j** | Because you are from a different part of the country than others | **7%** | **4%** |
| **44** | Were your handcuffs removed on arrival at the police station? | **76%** | **73%** |
| **45** | Were you restrained while in the police custody suite? | **25%** | **19%** |
| **46** | Were you injured while in police custody, in a way that was not your fault? | **30%** | **23%** |
| **47** | Were you told how to make a complaint about your treatment? | **6%** | **13%** |
| **48** | Were you treated well/very well by staff in the police custody suite? | **34%** | **34%** |

**Key to tables**

| | | 2012 Lewisham | Police custody comparator |
|---|---|---|---|
| | Any percentage highlighted in green is significantly better | | |
| | Any percentage highlighted in blue is significantly worse | | |
| | Any percentage highlighted in orange shows a significant difference in prisoners' background details | | |
| | Percentages which are not highlighted show there is no significant difference | | |
| **SECTION 4: Health care** | | | |
| **50** | Did someone explain your entitlements to see a health care professional if you needed to? | **43%** | **34%** |
| **51** | Were you seen by the following health care professionals during your time in police custody: | | |
| **51a** | Doctor | **29%** | **44%** |
| **51b** | Nurse | **44%** | **20%** |
| | Percentage seen by either a doctor or a nurse | **54%** | **51%** |
| **51c** | Paramedic | **3%** | **4%** |
| **52** | Were you able to see a health care professional of your own gender? | **30%** | **26%** |
| **53** | Did you need to take any prescribed medication when you were in police custody? | **28%** | **42%** |
| For those who were on medication: | | | |
| **54** | Were you able to continue taking your medication while in police custody? | **23%** | **35%** |
| **55** | Did you have any drug or alcohol problems? | **50%** | **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? | **64%** | **42%** |
| **57** | Were you offered relief or medication for your immediate withdrawal symptoms? | **27%** | **24%** |
| For those who were seen by health care: | | | |
| **58** | Would you rate the quality as good/very good? | **17%** | **31%** |
| **59** | Did you have any specific physical health care needs? | **37%** | **32%** |
| **60** | Did you have any specific mental health care needs? | **17%** | **24%** |
| For those who had any mental health care needs: | | | |
| **61** | Were you seen by a mental health nurse/psychiatrist? | **0%** | **18%** |