Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Metropolitan Police Service Borough Operational Command Unit of Newham

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

10–12 December 2013

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Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

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Section 1. Introduction

This report is part of a programme of unannounced 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.

The inspection of Newham police custody was the last Metropolitan Police Service (MPS) borough in the first round of inspections of police custody, which started in 2008. Our findings were a considerable disappointment. We found some of the worst conditions that we have seen anywhere in the MPS; it was clear that staff locally were not working effectively with the MPS territorial policing criminal justice (TPCJ) directorate, which seeks to ensure consistency in custody provision across all London boroughs. As a result there was a lack of strategic oversight and detainees were provided with poor care or in some cases were neglected.

The suite was chaotic; there were often too many people in the area in front of the desk, either waiting for a room to become free or with a detainee waiting to be booked in. Detainees were often denied proper respect or confidentiality. The cells were dirty, they were not always checked every day and the suite lacked supplies of basic items such as replacement clothing, food and tapes for interviews. Cell call bells were not loud enough, although detention officers answered as soon as they heard them. Staff did not know how to access the TPCJ intranet site, which has policies and information to assist them in their work in custody.

As elsewhere, Police and Criminal Evidence Act reviews were often carried out too early; this needed to be examined to ensure that it was not a permanent feature of new working arrangements across the MPS.

Health services were provided by a forensic medical examiner (FME), but detainees often had to wait over two hours to be seen and in some instances the FME was not called, despite the detainee having obvious health needs. Substance misuse services were reasonable, but there was no mental health liaison or diversion scheme to assist detainees with mental health issues. Custody was not used as a place of safety under the Mental Health Act.

This report provides a small number of recommendations to assist the force and the Mayor's Office for Policing and Crime to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course. However, given the poor outcomes for detainees we would urge both the borough and the MPS TPCJ directorate to take urgent action to improve custody facilities at Newham.

Thomas P Winsor
HM Chief Inspector of Constabulary

Martin Lomas
HM Deputy Chief Inspector of Prisons

April 2014

Section 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 the Association of Chief Police Officers (ACPO) *Authorised Professional Practice - Detention and Custody* 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 Newham police custody was among the busiest suites in London. With just one suite of 15 cells at Forest Gate police station, the borough also had an overflow suite at Plaistow police station, consisting of 11 cells, which at the time of the inspection was not being used. We examined the custody strategy, as well as treatment and conditions, individual rights and health care in the custody suite at Forest Gate police station; we did not inspect the custody suite at Plaistow police station. In the financial year 2012–13, 5960 detainees were held in the two suites.

Strategy

2.4 There was no strategic approach to custody that promoted the safe and decent delivery of custody. Senior leadership influence on standards of care in custody was limited, despite members of the senior leadership team (SLT) making visits to the suite. Newham had only nine permanent custody sergeants, who were managed by the custody manager and two custody support inspectors (CSIs), all of whom worked jointly with Waltham Forest and Barking and Dagenham. These boroughs also provided CSIs. Absences or staffing gaps were covered by neighbourhood policing teams.

2.5 Staff had insufficient control of the custody suite. The facility was often crowded and they did not know who was in the suite. Non-custody staff, not all of whom were easily identifiable, as well as solicitors and others filled the suite; all of them waited a long time to be dealt with. Some of the senior staff team made unprofessional comments about detainees' needs; fortunately most custody staff did not have these poor attitudes.

2.6 We were informed that custody was discussed at a range of meetings within the borough operational command unit (BOCU), but we did not see the minutes from these meetings, despite asking for them during the inspection.

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

2.7 Managers quality assured custody records through dip-sampling, including cross referencing person escort records (PERs) but not CCTV images, which were of particularly poor quality. Despite the dip-sampling process, we found entries in custody records to be basic.

2.8 The borough commander attended the Metropolitan Police Service (MPS) custody improvement board, led by the territorial policing criminal justice (TPCJ) directorate. Staff could not provide us with the correct contact details for independent custody visitors so we could not speak to them. Records in custody showed that they did not visit the suite frequently.

2.9 The MPS provided custody staff with training, including refresher training, centrally.

Treatment and conditions

2.10 The treatment of detainees in Newham often lacked proper respect. We did see custody sergeants acting considerately towards detainees, but some were distant, mechanistic and, at times, abrasive during the booking-in process. There was often no attempt to talk to detainees and we observed some inappropriate behaviour on the part of staff. The booking-in area was not private and there was not enough space between the three booking-in terminals. We observed detainees listening to other detainees being booked in next to them.

2.11 Women detainees were asked if they wanted to speak with a female officer and all were asked if they might be pregnant. There were no other specific arrangements for female detainees. Girls under 16 were not placed in the care of a named officer. No provision was available for detainees with disabilities.

2.12 Two detention rooms for juveniles were close to the custody desk, which was good; however, the condition of the cells was poor, for example, they had graffiti burnt onto the ceiling. Young people were dealt with correctly and appropriate adults (AAs) were contacted in most cases.

2.13 Unlike other London boroughs, there was no 'diversity box' containing religious material or equipment. We found a copy of the Qu'ran stored with reading material and the prayer mat lying on a shelf, which was disrespectful. Both were relocated during the inspection.

2.14 Although risk assessments were undertaken using the prompts on the national strategy for police information systems (NSPIS), a computerised booking-in system, some staff were less confident interacting with detainees to obtain as much information as possible to ensure they were cared for appropriately. Risk management was proportionate and items of clothing were not routinely removed. Children and young people were placed on 30-minute observations as were detainees who were in custody for the first time. DDOs were very clear about what was expected of them when they were conducting rousing checks. Constant supervision was well conducted: the custody sergeant briefed staff on what was required of them and we saw PC gaolers who were carrying out supervision engage well with detainees.

2.15 Eight cells had CCTV, but the picture quality was very poor and the system needed replacing. Non-custody staff took cell keys and spoke with detainees in cells unsupervised, which potentially undermined accountability in the suite. On several occasions we saw detainees left alone in consultation rooms or waiting in the booking-in area unsupervised.

2.16 Handovers were poorly managed, the booking-in area was not cleared, there were too many interruptions and DDOs were not always involved.

2.17 Pre-release risk assessments were perfunctory. Custody sergeants appeared to have the best intentions, but the chaotic environment in which they worked meant that they could not always go through the pre-release risk assessment thoroughly and could not therefore ensure detainees leaving their custody would be safe.

2.18 Too many detainees remained in handcuffs for too long. Strip-searching was proportionate, although the reasons for the search were not always recorded in the custody record. Use of force in custody was not recorded or monitored.

2.19 Detainees were held in dirty cells. Cells and communal corridors needed a deep clean; the floors had ingrained dirt and door frames and windows and ceilings were covered in graffiti. The cells were not cleaned between uses and some cells waiting to be occupied had stains on the floors. Daily checks of facilities were meant to be carried out in line with a standard operating procedure, but there were gaps in the process and not all cells were checked within each 24-hour period.

2.20 Call bells did not sound loudly enough at the custody desk, located in the noisy booking-in area. Nevertheless DDOs responded promptly when alerted. Detainees were not always told when or how to use the cell call bell. There were no records of a fire drill evacuation.

2.21 The management of stock at the custody suite was poor. There was, for example, a lack of blankets, replacement clothing and plimsolls. There were also no interview tapes, which could have prolonged detainees' stay in custody. Mattresses were old and flimsy and offered very little support. Towels were available and the showers delivered hot water, but no one was offered a shower. The microwave was filthy; the canteen provided poor quality meals. Some custody staff told us they saved canteen meals that were not used and reheated them later in the day, which was not appropriate. There was no exercise yard. Detainees were not routinely offered reading material, the stock of books was insufficient and there was nothing for young people or in other languages.

Individual rights

2.22 Custody sergeants could provide examples of when they had refused detention because the grounds were inappropriate, but staff were unclear about the use of alternatives to custody which were rarely used. Staff believed that both immigration detainees and prisoners being recalled to prison were held in police custody for longer than necessary. A nightshift CID team dealt with cases where appropriate, however some detainees were held in custody too long. In our analysis of 30 custody records, the average detention time was just under 17 hours, which was excessive.

2.23 Two AA schemes were in operation and we saw AAs from both attend promptly, although the scheme for young people did not operate overnight. Custody records did not always detail the time the AA was called or arrived or whether they were present at appropriate times. Custody staff told us that young people facing an overnight stay in police custody rarely obtained a local authority secure or non-secure bed and were consequently detained for longer than necessary.

2.24 We observed a failed attempt to use a touch-screen language terminal in the custody suite, where non-English speaking detainees could have their rights displayed in the language selected. We also saw a telephone interpreting service being used clumsily; the interpretation was not conducted via the double handset telephone provided for that purpose. Staff were aware of the location of rights and entitlements information in different languages on the police intranet site, but not all of them knew that an easy-read version was available. The leaflet detailing detainees' rights and entitlements was not always handed out to detainees during the booking-in process.

2.25 We observed delays in the processing of cases owing to the unavailability either of consultation or interview rooms, which led to congestion in the suite. Solicitors we spoke to confirmed this happened regularly and we saw one solicitor speaking to her client through the cell hatch, which was inappropriate. Solicitors were also kept waiting in the police station foyer.

2.26 We observed some perfunctory PACE reviews being conducted through cell hatches. The analysis of custody records revealed that many of the reviews were not undertaken at the correct time. Nine were carried out when the detainee was sleeping, with no evidence that the detainees were informed when they awoke. Not all detainees could appear in court promptly. The latest that local courts would accept a detainee were reported to be between 1.30pm and 2.30pm, which was too early. We were concerned about risk assessments and other documents sent to court loosely attached to the PER, causing a risk that they could be overlooked.

2.27 Custody staff gave mixed responses to questions about how they would handle a detainee wishing to make a complaint; some said they would direct detainees to the front counter of the police station.

Health care

2.28 The dedicated health care room had adequate storage and provision for clinical waste disposal, but the floor and hand-washing facilities failed to meet national infection control standards. Detainees waited on average just over two hours to see a forensic medical examiner (FME).

2.29 Detainees requiring a health assessment were seen by the on-call FME. We observed an FME provide appropriate and thorough clinical care, but confidentiality was compromised because a DDO was in the room regardless of a detainee's assessed risks. We found cases where there was no evidence that an FME had been called, despite a detainee having obvious health needs. Some good recording of the consultations were observed on the NSPIS medical form, but we also saw poorly completed records that would not have helped custody staff to deliver continuity of care. Verbal handover to custody staff was variable. Some FMEs were still inappropriately using personal log books to record the details of their consultations. Medication management was inconsistent as running balances were not recorded.

2.30 A substance use worker was in the suite at least twice a day to see detainees who had tested positive. All detainees were asked whether they wanted to see a drug worker. Detainees arriving overnight and testing positive were referred to their local service or an appointment was made for them in the community. Local links with community drug and alcohol services were good.

2.31 Detainees with acute mental health problems were referred to the local approved mental health worker (AMPH) service at the request of an FME. We were told that it sometimes took several calls to get a response on the telephone. Waits for assessment by the AMPH service were lengthy and custody staff told us of occasions when they could not be confident that assessments had not been influenced by local bed availability. There was no evidence of the suite being used inappropriately for detainees subject to section 136 of the Mental Health Act[2]; data showed that three section 136 detainees had been held there in the past year.

Main recommendations

2.32 The borough operational command unit senior leadership team should exercise greater influence and manage and monitor all aspects of custody to ensure that detainees are cared for appropriately during their time in custody.

2.33 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' guidance for monitoring purposes and to identify trends and learn lessons.

2.34 The suite should be thoroughly deep cleaned to ensure that detainees are held in decent conditions.

[2] 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.

Section 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 well-being of detainees.

Strategic management

3.1 The Metropolitan Police Service (MPS) had a territorial policing criminal justice (TPCJ) directorate, led by a commander based in territorial policing headquarters. The day-to-day management of Newham's custody suites and delivery of custody services had been devolved to the borough operational command unit (BOCU), led by the BOCU commander. The TPCJ was responsible for inspections for audit and compliance purpose, to ensure health and safety, and the implementation of the *Authorised Professional Practice – Detention and Custody*, published by the College of Policing.

3.2 Policies were signed off at a strategic command level at the MPS, and the TPCJ provided standard operating procedures (SOPs) that supported the delivery of police service policies in each MPS custody suite. The SOPs covered a broad spectrum, including the use of police custody and CCTV, and guidance on the supervision of detainees. They were designed to assist BOCUs deliver a consistent service.

3.3 The borough commander was responsible for the strategic leadership of the custody function for the borough of Newham. The senior leadership team (SLT) included a chief inspector who led the custody function, and managed a custody manager who was an inspector. The TPCJ maintained an organisational risk register for all MPS custody suites. The borough commander was responsible for implementing local work on risks and introducing measures to mitigate them.

3.4 There was a register of SLT visits to custody to oversee that risks were being managed, however, it was not evident that they influenced standards, which would have improved outcomes for detainees. We found no strategic focus to promote the safe and decent delivery of custody.

3.5 There was one designated full-time custody suite for the borough at Forest Gate police station (15 cells) and an overflow suite at Plaistow police station (11 cells), which was not in use.

3.6 Staffing in the custody suite at Forest Gate was not adequate with only nine permanent custody sergeants available. They were managed by the custody manager and two custody support inspectors. Management was shared with Waltham Forest and Barking and Dagenham boroughs, which also provided custody managers and custody support inspectors. We observed the regular use of custody-trained backfill sergeants from neighbourhood teams to cover for custody sergeant absences.

3.7 Custody sergeants managed and were supported by permanent designated detention officers (DDOs), who were responsible for the ongoing care and welfare of detainees. Only 15 DDOs were available for deployment in the custody suite and we observed the use of police constable (PC) gaolers, some of whom said that they had not received any custody-specific training, to cover DDO absences.

3.8 DDOs had received training to book detainees in under the supervision of custody sergeants and we saw them booking in detainees during our inspection.

3.9 We observed that management and custody staff did not control the custody suite because they did not know who was in the suite or who was in possession of cell keys, which affected outcomes for detainees. Non-custody staff, not all of whom were easily identifiable, as well as solicitors and others often filled the custody suite and waited a long time to be dealt with (see section on treatment and conditions, respect). Some managers made unprofessional comments about detainees' needs to us and to staff within earshot of non-custody staff, detainees, appropriate adults and solicitors. Fortunately, most custody staff did not have these poor attitudes.

3.10 A Grip and Pace meeting (which aims to move investigations forward) took place in the borough three times a day. It was usually chaired by a member of the SLT and attended by a custody representative who could raise custody issues. We were told that there had been no custody management meeting since July – a significant gap in the oversight and management of custody. However, a meeting had been arranged for December 2013. The meeting would be chaired by the chief inspector custody lead, and attended by the custody manager, custody support inspector, a custody sergeant and a DDO representative. Custody was an agenda item at the quarterly BOCU health and safety meeting, which the chief inspector custody lead attended. Despite requests, we did not see minutes of these meetings.

3.11 A process was in place to quality assure custody work along with an expectation that a 10% sample of custody records would be checked. The TPCJ template for dip-sampling custody records was comprehensive and included checking person escort record (PER) forms. Owing to the poor quality of CCTV recordings, cross referencing CCTV was difficult and did not routinely take place. There was an audit trail of feedback to officers via email. Despite the dip-sampling process, the custody record analysis showed that the quality of custody record entries were basic. Shift handovers were not quality assured.

3.12 There were effective processes for dealing with successful interventions: custody sergeants completed a form which was forwarded to the TPCJ, the custody manager, the borough health and safety manager and a representative from the Police Federation (the staff association for police constables, sergeants and inspectors). The chief inspector oversaw successful interventions, which we were told was an agenda item on the borough quarterly health and safety meeting. Lessons learned from the interventions and the Independent Police Complaints Commission (IPCC) *Learning the Lessons* bulletin were put on the TPCJ intranet site, which also contained policies and SOPs. Staff were expected to visit the site regularly to update themselves. Disappointingly, staff did not know how to access the TPCJ intranet site.

Recommendations

3.13 The borough should review the staffing levels of permanent custody sergeants and designated detention officers to ensure the safe and decent management of detainees at all times.

3.14 Police constables working as gaolers should receive appropriate training before undertaking the role.

3.15 The custody management meeting should be reinstated immediately, take place at regular intervals and provide effective oversight of the delivery of the custody function.

Housekeeping points

3.16 The quality assurance of custody records should include cross-referencing CCTV recording.

3.17 The borough should seek to improve the quality of entries in custody records.

3.18 Quality assurance processes should include dip-sampling shift handovers and should be recorded and auditable; feedback should also be provided.

Partnerships

3.19 Work with partners took place at a strategic level. The borough commander attended the Children's Trust board for safeguarding issues and had also previously attended the Metropolitan Police Service custody improvement board, led by the TPCJ. A detective superintendent represented the borough at a joint agency criminal justice forum overseeing all criminal justice issues.

3.20 An independent custody visitor (ICV) scheme covered the borough, but staff were unable to provide us with contact details for the local volunteers. The organisation later confirmed that it provided on average three visits per month and ICVs were usually admitted to the suite without delay. Immediate issues were dealt with and ICVs received feedback on outstanding issues. Police regularly attended quarterly panel meetings. The ICV register in the custody suite showed that custody visits were not frequent.

Recommendation

3.21 The borough, in conjunction with the Mayor's Office for Policing and Crime, should monitor and review the frequency of independent custody visitor visits to the custody suite.

Learning and development

3.22 All DDOs and custody sergeants had received centrally organised training before working in custody. Custody refresher training was provided for custody sergeants and DDOs, and staff we spoke with had either received this training or were scheduled to attend it.

Section 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 Overall the treatment of detainees was bordering neglectful. Although we observed some considerate interactions between custody sergeants and detainees, we also witnessed some abrupt exchanges that took place during the booking-in process when custody staff failed to respond to some detainees' confusion and anxiety. We observed a non-custody member of staff state that a burglar was expected, to which two custody sergeants simultaneously pointed to a detainee being booked in by a designated detention officer (DDO). The detainee was upset – he had not been charged with this offence and the comments made were within earshot of other staff in the suite. This was compounded by the poor state of the custody suite, and the lack of equipment and other items of stock, which meant custody staff could not provide detainees with adequate care. Some custody staff also appeared to believe that there was little they could do to improve matters (see sections on physical conditions and detainee care).

4.2 The custody suite was very small. There was not enough space between the three booking-in terminals and we observed some detainees listening to other detainees being booked in at the next terminal. We also saw too many non-custody staff waiting in the booking-in area while detainees were being dealt with. On one day, there were 16 people in the booking-in area while a detainee was being booked in and expected to respond to potentially sensitive questions about their offence or physical and mental health; there was no privacy and it was noisy. It was apparent that the custody suite was not being managed (see section on safety).

4.3 Girls aged16 or under were not allocated a named female officer who would have been responsible for their care. However, women coming into custody were appropriately asked if they wanted to speak to a female officer and if they might be pregnant so that they could be referred to the forensic medical examiner for a consultation. There was no provision for detainees with disabilities and the suite had no adapted toilets, lowered cell call bells or hearing loops.

4.4 Provision for children and young people was inadequate. Staff did not focus on limiting children and young people's time in custody and there were no common methods for dealing with them while they were there. Two detention rooms, which were the same as adult cells in their configuration but located close to the booking in area, were used for children and young people. Although the location was good, the cells were in poor condition with graffiti burnt onto the ceilings. We observed one young person with his appropriate adult (AA) being booked in for very sensitive offences; the booking-in area was not cleared during this process, which was poor practice. The young person looked overwhelmed by the activity in the booking-in suite. The custody sergeant took extra care when he explained the booking-in process to him, spending extra time with him to ensure that he understood what was being said to him. We observed other young people being booked in; they were dealt with appropriately and AAs were contacted promptly.

4.5 DDOs could not recollect receiving safeguarding training, but could explain, correctly, what they would do if a young person made an allegation involving abuse.

4.6 The custody suite had no diversity box containing religious material or equipment with instructions on how religious artefacts should be stored and handled. We found a copy of the Qur'an stored with some books and the prayer mat lying on a shelf, which was disrespectful. When we brought this to the DDO's attention they were more appropriately moved to a property store room. There was no way for Muslim detainees to determine the direction of Mecca in the cells or cell corridors. Sufficient copies of the Bible were available.

4.7 Staff knew how to search transgender detainees appropriately, although they had never done so, and they accurately referred to what they had been taught in their training. We saw all detainees being asked if they had any obligations to care for any dependants.

Recommendations

4.8 Booking-in areas should provide sufficient privacy to ensure effective communication between staff and detainees.

4.9 There should be clear policies, procedures and provisions to encourage custody staff to consider and respond to the distinct needs of children and young people in custody.

Housekeeping points

4.10 Girls aged 16 or under should be allocated a female officer who is responsible for their care.

4.11 A hearing loop should be available in the custody suite.

4.12 Religious observance items should be stored respectfully and there should be a way to identify the direction of Mecca.

Safety

4.13 Custody sergeants and DDOs booked in detainees and asked questions about their health, risks and individual needs, which were on the national strategy for police information systems (NSPIS) custody record system. The system was linked to the police national computer (PNC), which, if checked, highlighted warning markers concerning detainees' risks. We saw custody sergeants asking appropriate supplementary questions when detainees disclosed potential risks. We observed DDOs booking in detainees and although most were well conducted, some DDOs were less adept at eliciting as much information from them as possible to ensure that they received appropriate care. DDOs did not rephrase questions when detainees did not understand what was being asked and some appeared annoyed when detainees became agitated. This had a negative impact on the risk assessment process.

4.14 Our custody record analysis showed that all detainees received a risk assessment on arrival in custody. Risk assessments included detainee self-assessments and custody officer assessments. Generally, risk assessments appeared to include any relevant details about the detainee, although it was not always clear whether the PNC had been checked. There was some evidence of risk assessments being updated, for example once a detainee had sobered up, and observation levels on the whole appeared appropriate.

4.15 Custody sergeants managed risks proportionately using the risk assessment to determine the level of management required and did not routinely remove detainees' shoes or clothes. Children and young people were automatically placed on 30-minute observations as were detainees who were in custody for the first time. Intoxicated detainees were subject to rousing checks. The 4-Rs mnemonic (rousing procedure as set out in annex H to code C in the Police and Criminal Evidence Act 1984), was available in the custody suite and custody staff understood the importance of obtaining a response. Their good knowledge of the process was further supported by refresher training.

4.16 The constant supervision of a detainee was conducted during the inspection. There was a briefing from the custody sergeant about what was expected and some good interactions took place between the detainee and the PC gaolers conducting the supervision.

4.17 Eight cells were monitored by CCTV. The screen resolution of the monitors was poor and detainees could not be seen properly. Staff carried anti-ligature knives, and 'cutters', larger knives, were attached to cell keys.

4.18 We observed non-custody staff taking cell keys and visiting detainees, which was not appropriate. We saw detainees being left alone in consultation rooms or waiting in the booking-in area unsupervised on several occasions.

4.19 Some shift handovers were poorly conducted. The booking-in area was not cleared and there were too many interruptions from non-custody staff in the suite waiting to speak with custody sergeants. On more than one occasion custody sergeants had to ask staff in the custody suite to be quiet while they went through the handover. As a consequence, the handover took longer than necessary, with a knock-on effect on the length of time detainees were held in the outside holding area (up to an hour). The quality of the information handed over to the incoming shift was good, but not all DDOs were involved in the process.

4.20 A leaflet containing details of support organisations was explained to most detainees being bailed or released. Staff thought that it was only available in English, although there were actually other languages available on the force intranet. The busy, noisy atmosphere meant that custody sergeants could not always go through the pre-release risk assessment thoroughly enough to ensure the safety of detainees leaving their custody. We were concerned when we observed a heated exchange between a custody sergeant and Criminal Investigation Department (CID) staff member who refused to take a 13-year-old home. The incident took place in front of solicitors, AAs and other police staff. The young person was later taken home by a family member. Our custody record analysis highlighted inconsistent practices relating to the release of children and young people. In the sample we analysed it was not clear how two of the young people were getting home – one was released at 11.13pm and the other at 1.15am. One had asked to phone his mother earlier in the evening but had been unable to get through to her; it was not clear from the record whether he had made contact with her before he left custody. Three other pre-release risk assessments noted that the young people's parents were collecting them.

Recommendations

4.21 Custody sergeants should maintain better control of the number of staff waiting in the booking-in area.

4.22 CCTV systems should be updated to improve the quality of the images.

4.23 Custody sergeants and DDOs should receive their handovers together, in an area clear of other staff and detainees.

4.24 Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the detainees' position on release and any action that needs to be taken.

Housekeeping points

4.25 Non-custody staff should not have access to cell keys and visits to cells should be undertaken only by custody staff, or, if necessary, accompanied by them.

4.26 Detainees should not be left unsupervised in the custody suite.

Use of force

4.27 The majority of detainees we observed arriving at the custody suite were in handcuffs. However, too many remained in handcuffs while waiting to be booked-in or to enter the suite, as police staff failed to consider removing them when detainees appeared to be compliant. One Albanian female detainee was left in handcuffs throughout the booking-in process because the arresting officer had not searched her and was not sure what she might have in her possession. There were no warning markers on the PNC and she was compliant throughout.

4.28 Very few detainees were strip-searched and strip-searches we saw being authorised were proportionate. Data showed that strip-searching had been authorised 4303 times between 1 April 2013 and 8 December 2013, representing approximately 9% of all arrests, which was comparatively low compared with other Metropolitan Police Service (MPS) boroughs inspected. This was further supported by our custody record analysis, which showed that four out of 30 were strip-searched. Of the four detainees who were strip-searched, two were proportionate; however, the custody records of the other two did not contain enough information to explain the reasons for the search.

4.29 Use of force recording forms were not used. Custody sergeants told us that they recorded uses of force on the NSPIS system. Information on the use of force in custody suites was not collated locally or service-wide. All staff had been trained in approved safety techniques and received annual refresher training.

Housekeeping point

4.30 Subject to a risk assessment, detainees should have their handcuffs removed as soon as possible.

Physical conditions

4.31 The custody suite was in poor condition. The communal corridors contained ingrained dirt and needed a deep clean as did all the cells. Ventilation was poor and the atmosphere in the custody suite was stuffy and at times foul-smelling. There was graffiti in most of the cells around the door frames and windows and on some of the bed plinths. The two detention rooms had graffiti burnt onto the ceiling and children and young people held there could have found it very intimidating.

4.32 Daily cleaning arrangements were insufficient for such a busy custody suite. The cleaner could only attend to cells that were not occupied. When there was no cleaner in the suite, mattresses were not wiped down between uses and custody staff did not clean the cells after they had been used. Some cells waiting to be occupied had stains on the floor. We reviewed records of daily cell checks, including the checking of ligature points, cell call bells, toilet flushes, lights, mattresses and pillows. The records highlighted that some cells had not been checked for up to eight days because they were occupied when the daily checks were completed. This was inadequate and potentially unsafe. Additionally, the forms were not always signed off by a custody sergeant so they were unaware of the condition of the cells. There were appropriate arrangements for cleaning bodily fluid spills.

4.33 Cell call bells did not sound loudly enough at the front desk, which was located in the noisy booking-in area. Nevertheless, DDOs responded promptly to them when they heard them. Detainees were not always told when or how to use the cell call bell, but we did observe custody sergeants telling DDOs to explain what was in the cell to detainees who were in custody for the first time.

4.34 There had been no emergency practice evacuation in the previous year. There was a comprehensive emergency evacuation plan, with which staff were familiar. Adequate stocks of handcuffs were readily accessible.

Recommendation

4.35 All cells should be cleaned every day, kept free of graffiti and be well maintained, and the general improvement of the environment should be an urgent priority.

Housekeeping points

4.36 Mattresses should always be wiped down between uses.

4.37 All cells should be checked every day and cell checks should be recorded and signed off by the custody sergeant.

4.38 Detainees should have the cell call bell explained to them when they are located in a cell.

4.39 Emergency practice evacuations should be conducted and any lessons learned recorded and disseminated among custody staff.

Detainee care

4.40 The management of stock in the custody suite was poor and neglectful and had a negative impact on detainee care. On the first day of the inspection there were no clean blankets and no replacement clothing (aside from paper suits) and plimsolls were only available in limited sizes. In addition, there were no interview tapes, which could have meant detainees were held in custody for longer than necessary while staff obtained them. Custody staff told us that inadequate stocks were common and appeared resigned to the fact that, despite their requests for more, they did not arrive. We saw evidence of custody staff having requested a range of equipment in the weeks prior to the inspection. It was not until we informed managers of this that, except for replacement clothing, stock began to arrive in the custody suite.

4.41 Each of the cells contained a pillow and mattress; the mattresses looked old and offered very little support as they were well worn. Toilet paper was only provided on request. Hygiene packs for female detainees were available but not routinely offered. There were two showers, with hot water, that offered reasonable privacy. Towels were available and there were sufficient toiletries, but these were carelessly stored. We did not observe any detainees going to court being offered a shower; this was confirmed by our custody record analysis, where only one detainee who was held for over 15 hours had access to washing facilities. None of the other detainees in the sample could wash, including nine who were released straight to court, of whom six had been held for over 24 hours.

4.42 There was no replacement clothing; we observed two detainees who had had their clothing seized for evidence purposes wearing paper suits. Staff contacted the family of one of these detainees to ask them to bring in suitable clothing so he could be released. However, trousers were not brought in for him so he had to remain in custody for longer than necessary while his family was contacted again to bring in the item of clothing. No replacement underwear was available.

4.43 There was a discrete meal preparation area next to the booking-in desk, but we observed non-custody staff accessing the room for their own use of the microwave. It was therefore not surprising that when we looked at the two microwaves they were dirty. Despite informing custody staff of this, they were not cleaned.

4.44 Breakfast and lunchtime meals were provided through the onsite canteen which opened from 8am to 3pm. The lunchtime meals we observed detainees receive over two days were poor, for example, two very small fish fingers with rice, and the quantity was not sufficient. The canteen provided more suitable meals for breakfast. Some custody staff told us they saved canteen meals and reheated them for use later in the day, which was not appropriate. A stock of microwave meals was available and all were within the use-by date, but custody staff did not know where they were stored and were under the misapprehension that they had run out. This highlighted the lack of care shown towards detainees, as staff failed to ensure that suitable meals were available, including for those with special dietary needs. Although we observed that meals were offered throughout the day and at detainees' request, which our custody record analysis confirmed, we also found that five (17%) detainees were not offered a meal while in custody, one of whom (a 14-year-old) who had been held for nine and a half hours and another for 12 hours.

4.45 Custody staff referred to the holding 'cage', where detainees were required to wait prior to being brought into the custody suite, as the exercise area. It was not suitable. We observed two detainees being brought into this area, supervised by a member of staff, when there were other detainees waiting to be booked in. Only one detainee in our sample was offered some time outside. We were told that social visits were not allowed as there were no facilities where they could be safely conducted.

4.46 No sufficient reading material was available and there was nothing for young people or those who had difficulties reading or in foreign languages. Some staff asked detainees if they wanted something to read; only two in our record analysis were provided with anything.

Recommendations

4.47 There should be better management of stock in the custody suite to ensure detainee care.

4.48 Replacement clothing, including underwear, should be available for detainees whose clothes are soiled or have been seized.

4.49 An appropriate exercise yard should be provided so that detainees, particularly those who are held for more than 24 hours, can be offered exercise.

Housekeeping points

4.50 Detainees should have access to sufficient clean blankets.

4.51 Subject to an individual risk assessment, a small supply of toilet paper should be routinely placed in each cell.

4.52 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.

4.53 The practice of re-heating canteen meals should stop immediately.

4.54 Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable.

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

Section 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 Custody sergeants checked the reasons for detention with arresting officers to ensure that the grounds were appropriate. Sergeants told us that they were confident enough to refuse detention when the circumstances did not merit arrest and provided us with details of such cases. Alternatives to custody were available through Caution Plus 3 (voluntary attendance) and street bail[3], but custody staff believed they were rarely used. No data was available on the deployment of these alternatives.

5.2 Many detainees were booked in promptly on arrival, however we observed several having to wait up to an hour to be booked in, because the custody suite was busy (see section on treatment and conditions, safety).

5.3 Custody staff said they had a good relationship with Home Office staff based locally. However, they were concerned about the increasing amount of time immigration detainees spent in police custody; they waited up to three or four days for transport to take them to more suitable facilities. Data supplied by the Metropolitan Police Service (MPS) showed that between 1 April 2013 and 8 December 2013, immigration detainees spent an average of 21 hours in detention in the borough.

5.4 Staff also reported delays in police custody of up to three or four days at a time for prisoners who had been recalled to prison. They believed this was because of problems in identifying available prison spaces. The borough could not supply any relevant data. Staff believed that these lengthy stays in custody had an impact on cell availability; however, the borough did not monitor reported delays.

5.5 We observed investigations being progressed reasonably promptly; a nightshift Criminal Investigation Department team meant some cases were dealt with during the night. However, some detainees were held in custody too long. In our analysis of 30 custody records, the average length of detention was just under 17 hours; six detainees (20%) were held for more than 24 hours, including one who had been detained for over 54 hours. Only four detainees (13%) had been held for less than six hours. These figures were similar to the data provided by the MPS, which recorded that the average length of detention from 1 April 2013 to 8 December 2013 was 14 hours and 23 minutes.

5.6 Family members were used as appropriate adults (AA) whenever possible. When no such family member was available, AAs for young people up to the age of 17 were provided by the Appropriate Adult Service, which the local youth offending team contracted. They were available between 8pm and 11pm every day. AAs for vulnerable adults were provided by Mind and were available on a 24-hour basis. We observed AAs from both agencies arriving at the custody suite within an hour of being contacted.

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[3] Street bail under section 4 of the Criminal Justice Act 2003 enables a person arrested for an offence to be released on bail by a police constable on condition that they attend a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.

5.7 In our custody record analysis, six young people (20%) aged 17 and under were in our sample. In four cases it was not clear when the AA was contacted or when they arrived at the police station, although it was noted the AAs were present when detainees were told of their rights and entitlements and during interviews. One 16-year-old, who was in custody for 27 hours and was released straight to court, did not appear to have an AA present at any point during his time in custody. One 17-year-old in the sample arrived in custody at 11pm, but their AA did not arrive until 10.34am the next day, which meant they were present for the detainee's interview but not when their rights were read to them. Our custody record analysis showed an instance where the health care professional (HCP) recommended that a detainee have an AA present, but there was no evidence that one was requested.

5.8 Staff assured us the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989. Custody sergeants told us that they attempted to find alternative accommodation for young people who faced an overnight stay in police custody through the local authority children's services department, but were rarely successful; young people were therefore detained for longer than necessary. In our custody record analysis, one young person was detained before an appearance in court. A note in their custody record indicated that accommodation was sought through the children's services department, but that the request was refused as the detainee was a resident of a different local authority. It was not clear if any further attempts were made to secure alternative accommodation.

5.9 A touch-screen language terminal was mounted on a wall within the booking-in area; however it could only be operated from one of the three booking-in terminals. It displayed questions in the required foreign language, which staff were able to view in English on the linked booking-in terminal. We observed staff trying to use the terminal to book in a detainee but because the range of preset 'script' questions was too limited, the attempt had to be aborted. A professional telephone interpreting service was available and we observed it being used. Despite the availability of a double-handset telephone at the booking-in desk, on this occasion a single handset telephone was used, which meant it had to be passed backwards and forwards between the staff member and the detainee, a cumbersome and time-consuming process. Staff told us that a good face-to-face interpreter service was available for interviews. The police service had introduced 'virtual interpreters', who were available for interview purposes via videoconference; one of the interview rooms in the custody suite was equipped with the appropriate facilities. The detainee could choose between the alternative service and having an interpreter attend the custody suite.

5.10 A leaflet summarising a detainee's rights and entitlements was available during the booking-in process. It was poorly presented and potentially difficult to read, and some staff did not offer it to English speaking detainees. A similar version could be downloaded from the police service intranet site and printed for non-English speaking detainees in their own language and we observed this taking place. Not all staff knew that an easy-read pictorial format version could also be downloaded.

5.11 In our custody record analysis, 10 foreign national detainees (33%) were in the sample. One foreign national detainee, who had been given a copy of his rights in his own language, requested a solicitor. When the solicitor telephoned and asked to speak to the detainee, this was declined on the grounds that the detainee could not speak English. The risk assessment and reading of his rights, however, had been carried out without the assistance of an interpreter and the log stated that he needed 'some help' with English. An interpreter and the solicitor later attended the custody suite.

Recommendations

5.12 The Metropolitan Police Service should introduce a process for recording and monitoring voluntary attendance at police stations.

5.13 The borough operational command unit should actively monitor the length of time detainees are kept in detention to ensure that there are no unnecessary delays in progressing detainees' cases.

5.14 Appropriate adults should be available for all young people, including out of hours and when a health care professional identifies that a detainee requires one.

5.15 The borough operational command unit should engage with the local authority to ensure the provision of suitable alternative accommodation for young people facing an overnight stay in custody.

Housekeeping points

5.16 The MPS should further develop and promote alternatives to custody.

5.17 The rights and entitlement leaflet should be reviewed to ensure that it is easy to read.

5.18 Detainees should always be offered information about their rights and entitlements.

Rights relating to PACE

5.19 No Criminal Defence Service posters were on display to remind detainees of their right to free legal advice. A good supply of up-to-date copies of the Police and Criminal Evidence Act (PACE) codes of practice booklet were available, but custody staff did not routinely ask detainees during the booking-in process if they wanted to read them.

5.20 Detainees could not speak to legal advisers in private on the telephone. Calls were conducted at the main booking-in desk and on one occasion we observed a detainee trying to converse with his legal adviser while nine people, including detainees and police officers, stood close by listening to his conversation. We saw legal advisers routinely being offered either the front sheet or full printout of their client's custody record without having to request this.

5.21 We observed severe congestion in the custody suite (see section on treatment and conditions, respect) and detainee consultations with solicitors and interviews being delayed during busy periods because rooms were not available. Solicitors we spoke to advised us this was a regular occurrence as the custody suite only had two consultation rooms and two interview rooms. We observed that on one occasion a solicitor had to speak to their client through a cell hatch, which they explained they were comfortable with as their exchange was not confidential, but this was still inappropriate. We also met a solicitor who was kept waiting at the front desk for almost two hours. We were told this was because the custody suite was busy as a result of a shift handover.

5.22 We observed detainees being told that they could inform someone of their arrest, which staff facilitated, but this was not always recorded in the custody records we analysed. Staff monitored calls that detainees made to their nominated person to ensure they did not discuss their case. In our custody record analysis, all detainees had been routinely offered legal advice and just over half the sample (57%) had accepted the offer. In two cases involving foreign nationals, there were delays in contacting legal advisers. In the first case, the detainee requested a solicitor at 10.40am, however they were not contacted until 3.18pm; an entry in the custody log asked why this had not been done sooner. In the second case, a detainee asked for a solicitor during their first inspector review at 11am, but one was not contacted until 8.38pm.

5.23 Either the custody manager or custody support inspectors from the Newham, Waltham Forest or Barking and Dagenham boroughs conducted PACE reviews, as part of a tri-borough custody arrangement. We saw reviews taking place in person in most cases; however some were conducted through the door hatches and were superficial, and detainees were not informed that the inspector was authorising further detention. Some reviews were carried out very early. In our custody record analysis, 13 (50%) of 26 first reviews were carried out early, while three were late. Some of these reviews took place after the detainee had only been in custody for two to three hours, suggesting that inspectors were undertaking them when they were available in the custody suite. Nine reviews were conducted while the detainee was asleep and there was no evidence in logs that they had been reminded of their rights and entitlements once they had woken up. We did not observe any detainees being advised that reviews had been conducted while they were asleep, which was poor. We even saw an inspector who chose to conduct a sleeping review at 8.35am instead of waking up the detainee.

5.24 In general, processes for handling DNA samples were efficient, with regular collections.

5.25 The local magistrates' court would not normally accept detainees after between 1.30pm and 2.30pm on weekdays and after 9am on a Saturday, which was too early. As a result, detainees who were not charged until later in the morning remained in custody overnight. We observed the court refusing to accept one female detainee at 11.15am as there was no space in the court cells for her, however it was later agreed that she would be accepted provided the police got her to the court by 3pm. Person escort records (PERs) were completed for all detainees travelling to court; however, they were accompanied by extraneous paperwork, such as copies of risk assessments, which might have become detached or lost, which was inappropriate. A prisoner escort contractor was available for both morning and afternoon courts; however, staff reported they would not normally contact them for an afternoon court, choosing instead to take detainees in police vehicles to ensure they did not remain in custody longer than necessary.

Recommendations

5.26 Detainees should be able to make telephone calls to legal representatives in private.

5.27 Senior police managers should work with HM Court and Tribunal Service to ensure that early cut-off times do not result in unnecessarily long stays in police custody.

Housekeeping points

5.28 Posters detailing the right to free legal advice in a range of languages should be prominently displayed in the custody suite.

5.29 Legal advisers should be contacted and allowed access to the custody suite promptly.

5.30 PACE reviews should be conducted thoroughly and on time.

5.31 Detainees should be informed of any reviews carried out while they are sleeping, and a record to that effect should be made in the custody record.

5.32 The borough operational command unit should review the practice of adding extraneous paperwork to PERs.

Rights relating to treatment

5.33 Custody staff had mixed responses when asked how they would handle a detainee wishing to make a complaint. Some indicated they would notify the PACE inspector, while others said that they would advise detainees to make a complaint at the police station front counter following their release. In our custody record analysis, one detainee asked to make a complaint, but the custody sergeant refused to take it, as he thought he might have been the subject of the complaint. The sergeant indicated that he would bring the matter to the attention of the PACE inspector at the next review. However the detainee was asleep at that time and there was no further reference in the custody record to the complaint having been noted.

Recommendation

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

Section 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 The Metropolitan Police Service provided health care. On-call forensic medical examiners (FMEs) offered 24-hour cover. Mental health services were limited to the Newham local authority approved mental health professional (AMHP) service. Substance use services were provided by the Westminster Drug Project (WDP).

6.2 A dedicated health care room was located close to the custody desk. Clinical and equipment storage was adequate; some items were duplicated or overstocked. There were appropriate waste, clinical waste, sharps and drug disposal containers. Some loose items in cupboards and on the work surface needed to be disposed of, including an open sterile water container. The sink was grubby; the short-arm taps and lack of a wall-mounted towel dispenser meant that national infection control standards were not met. The floor was dirty and did not form a proper seal with the wall to meet infection control standards. The detainee chair and couch were not close to the door, where the panic alarm was located.

6.3 The locked fridge contained glucagon and a set of blood samples dated October 2013. The temperature was within the correct range, but we did not see records showing regular checks.

6.4 Access to the national strategy for police information systems (NSPIS), a computerised booking-in system, and a dual telephone handset for telephone interpretation were available.

6.5 FME response times were recorded on individual detainee records, but there was no management oversight. Detainee records showed detainees waiting on average just over two hours. There was no handover between FMEs and towards the end of shifts. When a call crossed shifts, custody staff had to make a new call to the next FME on duty. There were reasonable working relationships between FMEs and custody staff.

6.6 First aid kits and an oxygen cylinder were kept in the health care room and behind the custody desk; an automated external defibrillator (AED) was kept behind the custody desk. Regular equipment checks were completed by the designated detention officers (DDOs). Custody staff had received annual training in the use of the equipment and forensic kits had not exceeded their expiry date.

Recommendations

6.7 Cleaning arrangements and flooring in clinical areas should comply with infection control standards, as should hand-washing facilities.

6.8 Forensic medical examiner response times and quality of care should be monitored and managed to ensure detainees receive timely and appropriate care.

Housekeeping points

6.9 Forensic blood samples should be stored appropriately in the evidence freezer.

6.10 Fridge temperatures should be monitored regularly and checks recorded.

Patient care

6.11 Detainees were not routinely asked whether they wanted to see a health care professional. Detainees identified as having a health need were referred to the FME appropriately.

6.12 We observed an FME providing detainees with appropriate and thorough clinical care, but confidentiality was compromised by the presence of a detention officer in the room irrespective of the detainee's assessed risk. The consultations we observed were supported by detailed recording on the NSPIS medical forms.

6.13 Some recording on NSPIS medical forms was poor and there was not enough information to provide custody staff with a clear picture and ensure continuity of care. The medical form for one detainee who sustained injuries on his arms stated 'injuries noted'. Body maps were not used. Verbal handovers between custody staff were variable. FMEs used personal log books to record the details of their consultations instead of a formal secure clinical record.

6.14 In our custody record analysis covering a five-day period, three detainees, including two young people, stated they were asthmatic, but none were referred to the FME and it was not clear whether they had access to an inhaler during their time in custody. None of the young people during this period were seen by the FME, not even one who disclosed a history of self-harm. One young person said he had sickle cell disease for which he was not taking medication; in this case, an FME was requested, but there was no evidence that an FME had seen him. This young person was in custody for 15 hours.

6.15 FMEs gave detainees an initial dose of their prescribed medication and subsequent doses were placed in Henley bags (bags used for medication) attached to the custody boards for DDOs to administer using instructions and alerts on the NSPIS. Police made efforts to obtain prescribed medication from detainees' homes where possible. Detainees could have prescribed opiate substitution where the FME could verify the prescription, and officers collected it from the relevant community pharmacy. Symptom relief for withdrawal was prescribed and administered by FMEs or DDOs using the Henley bags. The medication given to detainees was recorded on the NSPIS.

6.16 A set of asthma inhalers for a previous detainee, no longer in the suite, had been left in an evidence bag behind the custody desk.

6.17 Medications, including controlled drugs, were stored in a locked cupboard in the health care room. A record was kept of the use of diazepam and DF118 (an opioid painkiller), but running balances were not recorded and the record showed variances in stock balances of both drugs. Keys were retained by the custody sergeant and given to the FME on request. FMEs did not always sign for controlled drugs.

6.18 There was no health promotion literature.

Recommendations

6.19 Consultations with detainees should be private and confidential from other custody staff, unless a risk has been properly identified.

6.20 All clinical consultations should be recorded using the eCHAPs system to ensure continuity of care and protect patient confidentiality in line with Caldicott requirements.

Housekeeping points

6.21 Detainees should always be offered the opportunity to see a health care professional.

6.22 Detainees should be given all their prescribed medication on transfer or release.

6.23 Records for all controlled drugs should show details of all stock and stock checks as well as maintain a running balance.

Substance misuse

6.24 A substance use worker visited the suite twice daily between 9.30am and 10pm Monday to Saturday and from 10am to 6pm on Sundays. Detainees who had tested positive or who were going to court were seen as a priority. All detainees were asked whether they wanted to see a drug worker. The drug worker and custody staff worked together closely.

6.25 Detainees arriving overnight and testing positive were referred to their local service or a community appointment. There were effective links between police and the substance use service; we observed a detainee brought in for defaulting on his mandatory community appointment.

6.26 Links and communication between local community drug and alcohol services, including local court services, were good. Detainees were given details of local needle exchange services. Young people were seen and referred to the local youth offending team.

Mental health

6.27 Detainees with acute mental health problems were referred to the local AMHP following an FME assessment. Custody staff told us they regularly had to make several calls to the local authority to get a response.

6.28 The NSPIS record of a detainee with a history of schizophrenia, who was witnessed displaying challenging behaviour, did not mention whether or not he had been referred for a mental health assessment despite the fact that he had said he had not been taking his regular medication.

6.29 Waiting times for an AMHP service assessment were lengthy and staff told us these could frequently be up to nine hours. Detainees requiring inpatient admission were transferred to Newham general hospital; custody sergeants told us they were not always confident that assessments had not been influenced by the availability of local beds.

6.30 There was no evidence of the suite being used inappropriately for detainees subject to section 136 of the Mental Health Act and data showed only three people were brought to the suite under section 136 in the past year.

Recommendation

6.31 Detainees showing clear signs of acute mental illness or indications of deterioration, including non-compliance with medication, should be referred to the AMHP service.

Housekeeping point

6.32 A log of waiting times for mental health assessment should inform discussions with the local authority on the risk to detainees being kept in custody.

Section 7. Summary of recommendations

Main recommendations

7.1 The borough operational command unit senior leadership team should exercise greater influence and manage and monitor all aspects of custody to ensure that detainees are cared for appropriately during their time in custody. (2.32)

7.2 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' guidance for monitoring purposes and to identify trends and learn lessons. (2.33)

7.3 The suite should be thoroughly deep cleaned to ensure that detainees are held in decent conditions. (2.34)

Recommendations

Strategy

7.4 The borough should review the staffing levels of permanent custody sergeants and designated detention officers to ensure the safe and decent management of detainees at all times. (3.13)

7.5 Police constables working as gaolers should receive appropriate training before undertaking the role. (3.14)

7.6 The custody management meeting should be reinstated immediately, take place at regular intervals and provide effective oversight of the delivery of the custody function. (3.15)

7.7 The borough, in conjunction with the Mayor's Office for Policing and Crime, should monitor and review the frequency of independent custody visitor visits to the custody suite. (3.21)

Treatment and conditions

7.8 Booking-in areas should provide sufficient privacy to ensure effective communication between staff and detainees. (4.8)

7.9 There should be clear policies, procedures and provisions to encourage custody staff to consider and respond to the distinct needs of children and young people in custody. (4.9)

7.10 Custody sergeants should maintain better control of the number of staff waiting in the booking-in area. (4.21)

7.11 CCTV systems should be updated to improve the quality of the images. (4.22)

7.12 Custody sergeants and DDOs should receive their handovers together, in an area clear of other staff and detainees. (4.23)

7.13 Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the detainees' position on release and any action that needs to be taken. (4.24)

7.14 All cells should be cleaned every day, kept free of graffiti and be well maintained, and the general improvement of the environment should be an urgent priority. (4.35)

7.15 There should be better management of stock in the custody suite to ensure detainee care. (4.47)

7.16 Replacement clothing, including underwear, should be available for detainees whose clothes are soiled or have been seized. (4.48)

7.17 An appropriate exercise yard should be provided so that detainees, particularly those who are held for more than 24 hours, can be offered exercise. (4.49)

Individual rights

7.18 The Metropolitan Police Service should introduce a process for recording and monitoring voluntary attendance at police stations. (5.12)

7.19 The borough operational command unit should actively monitor the length of time detainees are kept in detention to ensure that there are no unnecessary delays in progressing detainees' cases. (5.13)

7.20 Appropriate adults should be available for all young people, including out of hours and when a health care professional identifies that a detainee requires one. (5.14)

7.21 The borough operational command unit should engage with the local authority to ensure the provision of suitable alternative accommodation for young people facing an overnight stay in custody. (5.15)

7.22 Detainees should be able to make telephone calls to legal representatives in private. (5.26)

7.23 Senior police managers should work with HM Court and Tribunal Service to ensure that early cut-off times do not result in unnecessarily long stays in police custody. (5.27)

7.24 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to, complaints should be taken while they are still in police custody. (5.34)

Health care

7.25 Cleaning arrangements and flooring in clinical areas should comply with infection control standards, as should hand-washing facilities. (6.7)

7.26 Forensic medical examiner response times and quality of care should be monitored and managed to ensure detainees receive timely and appropriate care. (6.8)

7.27 Consultations with detainees should be private and confidential from other custody staff, unless a risk has been properly identified. (6.19)

7.28 All clinical consultations should be recorded using the eCHAPs system to ensure continuity of care and protect patient confidentiality in line with Caldicott requirements. (6.20)

7.29 Detainees showing clear signs of acute mental illness or indications of deterioration, including non-compliance with medication, should be referred to the AMHP service. (6.31)

Housekeeping points

Strategy

7.30 The quality assurance of custody records should include cross-referencing CCTV recording. (3.16)

7.31 The borough should seek to improve the quality of entries in custody records. (3.17)

7.32 Quality assurance processes should include dip-sampling shift handovers and should be recorded and auditable; feedback should also be provided. (3.18)

Treatment and conditions

7.33 Girls aged 16 or under should be allocated a female officer who is responsible for their care. (4.10)

7.34 A hearing loop should be available in the custody suite. (4.11)

7.35 Religious observance items should be stored respectfully and there should be a way to identify the direction of Mecca. (4.12)

7.36 Non-custody staff should not have access to cell keys and visits to cells should be undertaken only by custody staff, or, if necessary, accompanied by them. (4.25)

7.37 Detainees should not be left unsupervised in the custody suite. (4.26)

7.38 Subject to a risk assessment, detainees should have their handcuffs removed as soon as possible. (4.30)

7.39 Mattresses should always be wiped down between uses. (4.36)

7.40 All cells should be checked every day and cell checks should be recorded and signed off by the custody sergeant. (4.37)

7.41 Detainees should have the cell call bell explained to them when they are located in a cell. (4.38)

7.42 Emergency practice evacuations should be conducted and any lessons learned recorded and disseminated among custody staff. (4.39)

7.43 Detainees should have access to sufficient clean blankets. (4.50)

7.44 Subject to an individual risk assessment, a small supply of toilet paper should be routinely placed in each cell. (4.51)

7.45 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.52)

7.46 The practice of re-heating canteen meals should stop immediately. (4.53)

7.47 Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable. (4.54)

7.48 There should be a suitable range of reading material for detainees, including for young people, non-English speakers and those with limited literacy. (4.55)

Individual rights

7.49 The MPS should further develop and promote alternatives to custody. (5.16)

7.50 The rights and entitlement leaflet should be reviewed to ensure that it is easy to read. (5.17)

7.51 Detainees should always be offered information about their rights and entitlements. (5.18)

7.52 Posters detailing the right to free legal advice in a range of languages should be prominently displayed in the custody suite. (5.28)

7.53 Legal advisers should be contacted and allowed access to the custody suite promptly. (5.29)

7.54 PACE reviews should be conducted thoroughly and on time. (5.30)

7.55 Detainees should be informed of any reviews carried out while they are sleeping, and a record to that effect should be made in the custody record. (5.31)

7.56 The borough operational command unit should review the practice of adding extraneous paperwork to PERs. (5.32)

Health care

7.57 Forensic blood samples should be stored appropriately in the evidence freezer. (6.9)

7.58 Fridge temperatures should be monitored regularly and checks recorded. (6.10)

7.59 Detainees should always be offered the opportunity to see a health care professional. (6.21)

7.60 Detainees should be given all their prescribed medication on transfer or release. (6.22)

7.61 Records for all controlled drugs should show details of all stock and stock checks as well as maintain a running balance. (6.23)

7.62 A log of waiting times for mental health assessment should inform discussions with the local authority on the risk to detainees being kept in custody. (6.32)

Section 8. Appendices

Appendix I: Inspection team

Elizabeth Tysoe	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC lead staff officer
Nicola Rabjohns	HMIP health services inspector
Hayley Cripps	HMIP researcher
Joe Simmonds	HMIP researcher