Report on an inspection visit to police custody suites in Hackney Borough Operational Command Unit

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by

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1. Introduction

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

There are two principal custody suites in the London Borough of Hackney, at Stoke Newington and Shoreditch. Both are open 24 hours a day and receive juveniles as well as adults. A smaller suite at Hackney police station is opened only when required to support specific police operations. All three suites were visited, although the report focuses on the larger two facilities. Assessments were also informed by a survey conducted by HM Inspectorate of Prisons' researchers of prisoners at HMP Brixton who had previously been held in Stoke Newington and Shoreditch.

Strategic oversight of the suites was provided by the Metropolitan Police Service (MPS) custody directorate, which seeks to ensure consistency through the issuing of standard operating procedures to all London boroughs. Day-to-day management is devolved to borough commanders. The Metropolitan Police Authority (MPA) has responsibility for the estate and manages an active body of independent custody visitors.

The Hackney suites benefited from a clear local management structure. There were trained designated detention officers, but custody sergeants and police constable gaolers were not permanent and the latter lacked specific training for the role. There were examples of good partnership working, including with mental health service providers and the Crown Prosecution Service. Managers were keen to learn lessons from Independent Police Complaints Commission publications and complaints from the public, but use of these sources of information was not systematic.

We observed appropriate and respectful relationships between staff and detainees. Staff used de-escalation techniques well to defuse aggressive encounters. However, staff demonstrated limited awareness of the specific needs of juveniles and female detainees, access for those with disabilities was limited, and fire evacuation arrangements required improvement. Similarly, while risk assessments were thorough, inspectors found a number of potential ligature points in the rather tired accommodation, and more could be done to aid detainees' access to hygiene arrangements.

Staff took a rigorous approach to ensuring that the provisions of the Police and Criminal Evidence Act were adhered to, although this also meant that appropriate adults were not sought for children of 17. A significant number of immigration detainees were held, and some were not expeditiously processed by the UK Border Agency. While DNA samples were efficiently dealt with overall, some had not been submitted appropriately to the national DNA database. The making of complaints was not facilitated.

[1] Optional Protocol to the United Nations Convention on the Prevention of Torture and Inhuman and Degrading Treatment.

Clinical governance arrangements for healthcare required improvement, as did oversight of attendance times by forensic medical examiners. Some clinical rooms were in poor condition, and medicines management required thorough review. Custody staff demonstrated good patient care, and support for those with substance misuse issues were good. Mental health services were exceptionally good.

This inspection of custody suites in Hackney identified some good practice, but also a number of areas for improvement. In particular, staff need to be properly trained for their tasks, not least to ensure appropriate recognition of the needs of the diverse range of detainees who pass through the suites. Healthcare provision also required improved management to ensure that a comprehensive and accountable service is provided.

This report sets out a number of recommendations that we believe will assist the MPS and the MPA to improve the quality of custody provision in Hackney. We expect these recommendations to be considered in the wider context of MPS\MPA priorities and resourcing, and for an action plan to be provided in due course. Some recommendations also have national implications and we will progress these directly with the appropriate organisations or authorities.

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March 2010

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections 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* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*[2] about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.

2.2 The Metropolitan Police Service (MPS) has 77 custody suites designated under the PACE 1984 for the reception of detainees. Twenty-five are 'overflow custody suites', used for various operational matters such as charging centres for football matches or immigration detention. One suite is available for use when Operation Safeguard (overflow from prisons) is running. The remaining 51 custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.

2.3 This unannounced inspection was conducted at Stoke Newington and Shoreditch custody suites in the London Borough of Hackney. Custody facilities at Hackney police station were also visited. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and healthcare in the two custody suites. A survey of prisoners at HMP Brixton who had formerly been detained in Stoke Newington and Shoreditch custody suites was conducted by HM Inspectorate of Prisons researchers and an HM Inspectorate of Constabulary staff officer to obtain additional evidence (see appendix).

2.4 Stoke Newington had 16 cells and Shoreditch had nine. They were open 24 hours a day and held adults and juveniles. Hackney had five cells and was opened for specific police operations only. The suites had received 12,158 detainees in the year to the inspection (7,612 at Stoke Newington, 4,317 at Shoreditch and 229 at Hackney). In 2009, 365 immigration detainees had been held, mainly at Stoke Newington.

Strategic overview

2.5 The MPS custody directorate within the Operation Emerald territorial policing team had strategic oversight of custody in all boroughs in London. Standard operating procedures (SOPs) were issued to boroughs and aimed to assist in the delivery of a consistent level of service in custody. The Metropolitan Police Authority (MPA) had responsibility for the custody estate and the official who managed the independent custody visitors (ICV) scheme also had lead responsibility for reporting on custody matters to the MPA. There was an active local ICV scheme, to which the borough was responsive.

2.6 There was a lack of capacity in the borough's custody estate and little prospect of this changing significantly. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs. Responsibility and accountability for custody in Hackney therefore rested with the borough commander, who was a chief superintendent. There was a clear management structure overseeing custody in the borough.

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

Reporting by exception was the main approach adopted and a series of formal meetings facilitated this process.

2.7 Custody sergeants and police constable (PC) gaolers were not permanent, but instead were drawn from operational policing teams. There was some confusion among them about processes and systems in use. They were supported by a small number of designated detention officers (DDOs) who were permanent staff in the custody suites. Custody sergeants and DDOs attended nationally approved custody training, but PC gaolers did not and had only minimal training for the role. There was no locally organised refresher training.

2.8 Some good partnership work was evident, notably with mental health, the Crown Prosecution Service (CPS) and UK Border Agency (UKBA).

2.9 A newly introduced action plan aimed to analyse and learn lessons from complaints made by the public, but there was confusion among staff and managers about how the complaints system worked in custody.

2.10 Independent police complaints commission (IPCC) learning the lessons newsletters and other good practice information was circulated to staff. There was no borough-wide collation of use of force to enable trends and patterns to be analysed.

Treatment and conditions

2.11 Relations between staff and detainees were relaxed and respectful, with first or preferred names used. Juvenile and female detainees were treated much the same as other detainees and staff had limited awareness of how they might be particularly vulnerable in custody. Access for detainees with disabilities was not adequate at Shoreditch and neither suite had an adapted cell or toilet. Shoreditch had only limited materials for worship.

2.12 Booking in desks did not allow much privacy. Detainees were thoroughly risk assessed and anyone posing a higher risk was placed in a cell with closed-circuit television (CCTV). We found a small number of ligature points in detainee areas and not all staff carried anti-ligature knives. Force was not over-used and officers used de-escalation techniques when dealing with aggressive detainees. Staff did not always explain the use of cell bells, but when activated by detainees these were responded to quickly. Not all staff were aware of fire evacuation procedures. Both suites were tired and grubby and there was a lot of graffiti in cells, some of it gang related.

2.13 Showers were rarely offered and, in line with MPS policy, only paper towels were available. Every cell had a mattress and pillow, but these were not usually cleaned after use. Detainees had to request blankets at Stoke Newington, and toilet paper was not routinely available at either custody suite. Replacement clothing and plimsolls were available, but no underwear and nothing in smaller sizes. A range of meals, including halal and vegetarian meals, was provided, but detainees were not offered all the available options and staff had not been trained in food hygiene. There was no access to outside exercise, visits were rarely allowed and there was only limited reading material.

Individual rights

2.14 Custody sergeants checked that arrest and detention were appropriate. Custody was not used as a formal place of safety for children and young people under section 46 of the Children Act 1989. The number of immigration detainees held was quite high and some stayed in custody

too long. Professional interpreters were used when necessary and there were few delays apart from healthcare consultations occasionally. Rights and entitlements information was available in a range of languages. Pre-release risk assessments were carried out for all detainees.

2.15 PACE was adhered to. Detainees were not interviewed while under the influence of alcohol or drugs, and eight-hour rest periods were provided. Defence solicitors reported good working relationships with staff. Appropriate adults were available in the day and evening, but not out of hours. Police adhered to the PACE definition of a child, which meant those aged 17 were not routinely provided with an appropriate adult. There was an efficient system of processing detainee DNA samples, but some PACE, evidential and volunteer samples had not been submitted to the national DNA database or processed accordingly. A small number of samples were linked to serious crimes. Court cut off times were early, which meant detainees were not processed as quickly as they might have been, leading to longer stays in custody than was otherwise necessary. There were no video link facilities.

2.16 Detainees wanting to make a complaint were often told to do so at the front of the police station on release, which meant that those detainees taken to court or sent to prison had less opportunity to have their complaint investigated.

Healthcare

2.17 Governance arrangements for healthcare were managed centrally by the MPS. Clinical governance arrangements were unclear and there was little ownership of the provision in the borough operational command unit (BOCU). There was an absence of robust monitoring and policies to ensure provision was meeting need and management arrangements were not systematic.

2.18 The management of clinical rooms was poor and they were not sufficiently clean. There was overstocking of medications, not all medicines were stored securely and some were out of date. There were serious discrepancies in the stock management of some controlled drugs. Recording of checks of defibrillators was inadequate and first aid bags were not regularly checked.

2.19 Our custody record analysis indicated that the average wait for a forensic medical examiner (FME) was 2.5 hours, but staff described some very long delays. There were some long waits of several hours during the inspection caused by a pre-planned police operation that custody staff had not been forewarned about. Custody staff demonstrated some good patient care. Most FMEs, but not locum doctors, had access to NSPIS. Inspectors had some concerns about the storage of clinical records.

2.20 Drugs services were good, with good continuity of care. Needle exchange was not provided on site. There were good links to community provision. Alcohol services were only signposted. There was a new triage diversion scheme for juveniles.

2.21 Mental health services were very good. There was a strong relationship between the police and providers, supported by a mental health liaison officer and the fact that there was a substantial psychiatric hospital in the borough with a dedicated Section 136 (Mental Health Act) suite. Mental health awareness training had been provided to a range of police staff, including those working in custody.

Main recommendations

To the Metropolitan Police Service

2.22 All staff and other employees who operate within the custody environment should not be deployed into custody suites until they have been given custody specific training, which includes training in how to use the NSPIS custody system.

2.23 Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults in custody.

2.24 All PACE DNA samples should be submitted to the national DNA database or destroyed as soon as practicable, if no longer required.

2.25 Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners.

2.26 Managers should ensure that all custody staff and healthcare professionals adhere to the newly introduced guidelines for the security, management, administration and disposal of drugs and medicines in custody. The discovery of missing medicines, particularly controlled drugs, should immediately be notified up the chain of command and to the PCT accountable officer.

3. Strategy

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

3.1 The territorial policing commander was the chief officer lead on custody for the MPS. The custody directorate had an inspection function: a detective chief inspector, an inspector, a sergeant and a member of police staff had individual responsibilities for audit and inspection, health and safety and the implementation of SDHP guidance. The commander sat on the programme board for SDHP and was clearly focused on ensuring an emphasis on 'professionalising custody'. He was also preparing to introduce integrated prosecution teams and 'virtual courts' through video links in newly built or refurbished custody suites.

3.2 Custody policies were signed off at a strategic command level within the MPS and the custody directorate provided SOPs that supported delivery of force policies by custody suites in each London borough. The SOPs covered a broad spectrum, including use of police custody, use of CCTV and guidance to custody staff on the supervision of detainees. They were designed to assist boroughs to deliver consistent levels of service, although responsibility and accountability for their delivery had been delegated to borough commanders.

3.3 The MPS's asset management plan had stalled due to the wider economic situation. This had led to a 'rephasing' of the building plans, with priority focused on the most pressing need. Hackney borough had two main custody suites, Stoke Newington and Shoreditch. We were told by management that a third custody suite at Hackney was used rarely and only for specialist operations, but they were unaware that it had recently been used by specialist units. There was not enough capacity to meet current need and there was little prospect of any increase in the near future.

3.4 The borough commander for Hackney was a chief superintendent. The senior management team (SMT) lead for custody was the chief inspector, who line managed the custody manager. The custody manager was an inspector and the deputy custody manager was a sergeant. The borough commander believed the borough had a strong chain of command reinforced by oversight mechanisms that allowed custody issues to be highlighted and tracked. Members of the SMT were encouraged to visit the custody suites and such visits were genuinely appreciated by frontline staff.

3.5 Performance management was based on exception reporting. This relied on the SMT having a clear picture of custodial issues, either through exception reports or through these being highlighted by another oversight mechanism such as the daily management meetings (DMMs). DMMs were augmented by a borough support management information report, which considered performance issues such as complaints, outstanding warrants and detainees who had been bailed. The borough commander also chaired the bi-monthly local criminal justice board meetings attended by a number of criminal justice partners. A quarterly custody user forum meeting was chaired by the custody chief inspector and attended by a range of police staff and partner agencies.

3.6 There was a MPA lead for the ICV scheme, which was viewed as an important independent oversight mechanism, and the post holder also led for the MPA on custody matters. ICVs visited the custody suites regularly and were clearly focused on standards and prisoner welfare. The custody manager picked up issues of concern and reported back on progress at

formal ICV meetings. ICVs described good relationships with custody staff and responsible managers. The custody manager said relationships with the ICVs were good. He regularly attended their meetings and the borough commander had also attended a couple of meetings. ICVs expressed concerns about changes to the frequency of their panel meetings from every six weeks to quarterly and said the MPA had not consulted them about this change.

3.7 The custody teams were not permanent, with police sergeants and PC gaolers 'posted' into the custody suites from frontline uniform shifts where they were also line managed. At least 45 custody sergeants covered both custody suites from the uniform shifts, with about nine sergeants on each shift assisted by PC gaolers and DDOs. As a result, there was some confusion among sergeants and PC gaolers about systems and processes in custody. The borough commander was in favour of implementing dedicated custody teams within the MPS, which he believed would lead to a more consistent approach in custody suites.

3.8 There could be two inspectors on duty at any one time: one duty officer who dealt with critical incidents and one custody manager responsible for managing the custody suites. The duty officer was also referred to as the 'PACE inspector' and carried out the PACE reviews of detentions and ensured that detainees were dealt with appropriately. Core team sergeants had line manager responsibilities for the DDOs, but not for custody sergeants. The police officers worked eight and nine-hour shifts. Apart from the night shift, there was no allocated time for formal handovers and the system relied instead on officers arriving early to complete these.

3.9 All custody sergeants and DDOs had received nationally approved custody training delivered corporately. However, apart from initial training on how to use the NSPIS custody system, PC gaolers had not received custody specific training before their deployment into the custody suites. Their custody training consisted of one 'on the day' training period before effectively being left to get on with the tasks in hand. This was far from ideal and increased risks for detainees and the MPS. We understood that the MPS had recently brought in a custody sergeant refresher course for staff who felt deskilled, but there was nothing locally to refresh police custody sergeants.

3.10 There were very good local partnerships with the National Health Service and Mental Health Trust (see section on healthcare). The borough commander also described 'very strong working relationships' with the CPS. A new Chief Crown Prosecutor who had arrived in December 2009 was in regular contact and any local difficulties were usually overcome quickly. Relationships with the UKBA were also described as strong (see section on individual rights).

3.11 The borough commander had worked with the Department for Professional Standards (DPS) to launch an organisational action plan on 5 January 2010. This sought to learn lessons from complaints, including those originating from custody, and highlighted themes and trends. However, confusion over how the complaints system was operating risked undermining this initiative (see section on individual rights).

3.12 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points from investigating adverse incidents. They also published a 'best of lessons learned' from the IPCC, which the borough ensured were circulated while also feeding back its own lessons learned from successful interventions with detainees.

3.13 Use of force in custody suites was not collated at a local or force-wide level. Officers and staff recorded the use of force against detainees in their custody records and police officers recorded it in their evidential pocket note books.

Recommendations

To the Metropolitan Police Service

3.14 Custody refresher training should be provided to all staff who work within the custody environment as a matter of course.

3.15 The use of force should be monitored locally and at a force-wide level, for example by ethnicity, location and officer involved.

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 The booking in process was respectful and detainees were usually addressed by their first names. Staff aimed to create a professional but relaxed environment. Staff had limited understanding of how young people and women may be particularly vulnerable in custody. Juveniles were held in detention rooms nearest to the booking in desk and appropriate adults were used for those under the age of 17. Female detainees were asked whether they wanted to speak to a female staff member. Otherwise, neither group was treated substantively differently to adult male detainees.

4.2 Stoke Newington provided adequate access for detainees with disabilities, but no adapted toilets, while access to Shoreditch was more limited as there were a couple of steps at the entrance. Neither suite had any specially adapted cells. A hearing loop was available from the front office at Shoreditch, but Stoke Newington did not have one.

4.3 The booking in desks at both sites were an appropriate height, but the front desk areas were open and offered little privacy. All telephone calls, including to solicitors, were made at the front desk. The CCTV screens at the front desks could be observed by detainees and others, particularly at Stoke Newington.

4.4 A Bible, Qur'an and prayer mat were available at Stoke Newington, but Shoreditch had only a Bible.

Safety

4.5 There were no holding rooms, so at busy times detainees were usually held in vehicles until called through by custody staff. All detainees were subject to a risk assessment on arrival and the Police National Computer (PNC) was routinely interrogated for safety markers. Staff used all the evidence available to assess risk and applied common sense when interpreting it.

4.6 No detainees shared a cell. Detainees considered at higher risk were held in cells with CCTV, of which there were six at Stoke Newington and four at Shoreditch. Items such as laces, belts and chains were removed during the booking in process, but detainees were not given the opportunity to re-lace their shoes before release. Intoxicated detainees were roused regularly. PC gaolers carried ligature knives and cell keys, but custody sergeants did not.

4.7 Safety information was properly shared at custody sergeant handovers. Staff received regular newsletter updates about detainee safety from the custody directorate (see section on strategy) and a report form was completed and forwarded to senior management following any near misses in custody.

Use of force

4.8 Detainees arriving in custody were given a rubdown search and usually had handcuffs removed before being booked in. Handcuffs and velcro belts were available and custody sergeants carried CS gas, although they said this was not used in custody. Custody sergeants were given advance warning of any violent detainee due to arrive and made suitable arrangements to manage the situation.

4.9 Officers used de-escalation techniques and we saw these in practice when an angry detainee was talked to until he calmed down. Our detainee interviews and custody record analysis did not indicate that force was overused, although local monitoring of this was limited. Staff received use of force training and this was regularly refreshed. A doctor was usually called following a use of force, particularly if there were any physical injuries. The use of force was recorded in the individual detention logs but was not recorded centrally (see section on strategy).

Physical conditions

4.10 The custody suites were reasonably well maintained, but were tired and grubby and some cells had spit on the walls. The flooring at both suites were due to be replaced in April 2010. The environments were reasonable, but cramped. Most potential ligature points had been filled in, although some were still evident and we passed details of these to the force.

4.11 There was a lot of graffiti in cells, especially on the benches and around the door frames. Some was gang related, which served to reinforce a gang culture in the community. The cells were cleaned by cleaners twice a day, but staff were unaware of any cleaning schedules. PC gaolers and DDOs cleared up any debris left in cells between use, but did not routinely wipe down pillows and mattresses.

4.12 Both custody suites had a no smoking policy. Nicotine replacement was provided at Stoke Newington if prescribed by a doctor, but not at Shoreditch.

4.13 Fire alarms were tested regularly. Staff were generally aware of fire safety procedures, but there was no evidence of any evacuation drills and not all staff knew where the sets of handcuffs to use in an evacuation were locked away.

4.14 Staff said they explained the use of cell bells when a detainee was first locked up, but we did not always see them doing so and only 7% of respondents to our survey, against a comparator of 23%, said cell bell use had been explained. Cell bells were responded to promptly during the inspection.

Personal comfort and hygiene

4.15 All cells contained a mattress and pillow. Blankets were offered to detainees at Shoreditch, but were only available on request at Stoke Newington. There were no anti-tear blankets at either site. There were dirty blankets in the shower area at Shoreditch and they were stored outside a cell at Stoke Newington.

4.16 Sanitary items were available for women, but only provided on request. Other hygiene items such as toothbrushes, toothpaste, razors and shower gel were also available at both sites. Detainees could use the toilet in private, but had to request toilet paper. In our survey, only

36% of respondents, against a comparator of 53%, said they had routinely been given toilet paper. Hand washing facilities were provided, but not in cell. Showers allowed good privacy, but detainees were rarely offered one and both sites had only paper towels for detainees to dry themselves.

4.17 Paper suits, sweatshirts, jogging bottoms and plimsolls were available for detainees whose clothing was seized, but not in small sizes and neither site had a supply of underwear. Family and friends were allowed to bring in replacement clothing.

Catering

4.18 Hot and cold drinks were routinely provided on request. The staff canteen offered a good range of breakfast, lunch and dinner meals at both sites on weekdays and Saturday mornings. There was also a good range of microwaveable meals, including halal and vegetarian meals, but detainees were not offered all the available options and some of the meals were out of date. Staff had not been trained in food hygiene.

Activities

4.19 Detainees could not have outdoor exercise as there was no exercise yard at Stoke Newington and the one at Shoreditch was out of use. Both sites had only limited reading material and this was not routinely offered to detainees. There were no visits rooms and visits were not allowed except in exceptional circumstances.

Recommendations

4.20 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities.

4.21 A range of materials for the observance of all major faiths should be available at Shoreditch.

4.22 All staff should carry anti-ligature knives.

4.23 All cells and detainee areas should be clean, fit for purpose and free of ligature points.

4.24 A force-wide policy to address graffiti should be developed and implemented.

4.25 Subject to individual needs assessment, nicotine replacement should be available to detainees.

4.26 Staff working in the custody suite should be familiar with fire safety arrangements.

4.27 Toilet paper should be provided routinely.

4.28 Detainees held overnight and those who are dirty should be offered a shower and clean towels.

4.29 Wherever possible, detainees held for longer periods should be offered outdoor exercise and visits.

Housekeeping points

4.30 Mattresses and pillows should be wiped down after use.

4.31 Dirty blankets should be stored appropriately.

4.32 Detainees whose clothing is seized should be given suitable alternative clothing, including underwear.

4.33 Detainees should be offered a choice of all the available options of microwave meals and all should be in date.

4.34 A cordless telephone should be provided to allow detainees to consult solicitors in private.

4.35 Detainees should have access to suitable reading material.

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 that arrest and detention were appropriate and took all available steps to reduce the amount of time detainees spent in custody. Detainees could let someone know where they were or staff would do this on their behalf if necessary. Detainees were also asked on arrival if they had any concerns about people who were dependent on them and action was taken to resolve this if required.

5.2 Staff said custody was not used as a formal place of safety for children and young people under section 46 of the Children Act 1989.

5.3 A relatively large number of immigration detainees were held, with 365 in 2009. Records indicated that their average length of stay was 11.25 hours, with the norm less than this. Staff reported good relationships with the UKBA. Two UKBA staff were based at Stoke Newington so problems could easily be resolved, but a few immigration detainees still spent a long time in police custody, with one in 2009 detained for nearly four days.

5.4 A professional telephone interpreting service was routinely used when detainees with little or no English were booked in. A good range of interpreters was also available. Apart from some healthcare consultations (see section on healthcare), there were few delays in accessing an interpreter and staff described one delay of 14 hours highlighted by our analysis of custody records as the exception rather than the rule. This tended to happen when detainees held required interpretation in less common languages. Rights and entitlements information was available in a wide range of languages, but few notices were displayed in languages other than English.

5.5 Pre-release risk assessments were carried out for all detainees and appeared to be a normal part of the custody sergeant's responsibilities. The main action taken was arranging lifts home, but a list of useful contact organisations was also offered.

Rights relating to PACE

5.6 PACE was adhered to and the codes of practice were offered to detainees to read. There was no evidence that detainees were interviewed while under the influence of alcohol or drugs, and eight-hour rest periods were provided.

5.7 Defence solicitors were generally positive about working relationships with staff, who they said were respectful to detainees and adhered to their rights and entitlements. However, some complained that their telephone calls to the custody suite were not always answered promptly, a point that was also made by ICVs. Staff tried to use friends and family as appropriate adults (AAs) in the first instance. Mind provided the AA service for juveniles and adults between 8am and 11pm. This appeared to work well, but there was effectively no out-of hours-service and in some cases this had led to delays in taking matters forward. Juveniles under 17 were not

interviewed unless accompanied by an AA, but Hackney adhered to the PACE definition of a child instead of the Children Act 1989 definition, which meant those aged 17 were not routinely provided with an AA. Although meeting the current requirements of PACE, in all other domestic law and under the United Kingdom's international treaty obligations, 17 year olds are considered to be juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot becomes available.

5.8 DDOs in both suites operated an effective and efficient system of processing detainee DNA samples in custody fridges and freezers. A freezer and fridge in the CID general office at Shoreditch needed samples and exhibits to be reviewed. There was only a small number of these, but they were linked to more serious offences. Some PACE, evidential and volunteer DNA samples had not been submitted to the national DNA database (NDNADB) or processed accordingly and the reason for this was unclear. The samples included some linked to violent crimes, rape and homicide, although the homicide sample appeared to have been taken and dealt with by an investigation squad not based in the borough. The freezer at Stoke Newington contained PACE DNA samples, some of which may have been evidential samples, taken in February, June, July and November 2009. They had not been sent to the NDNADB or disposed of.

5.9 Court cut off times were early and staff said it was not possible to get a place after 1pm, regardless of a detainee's vulnerability or circumstances. This resulted in detainees spending more time in custody than would otherwise be necessary. There were no video link facilities.

5.10 Full copies of custody records or front sheets were available to detainees and their legal representatives.

Complaints

5.11 Detainees arriving in custody were not told how to make a complaint. Custody staff said, and we saw, that detainees wanting to complain were often told to do so at the front of the police station when they had been released. This left anyone taken straight to court or sent directly to prison with little opportunity to have their complaint heard or investigated and potentially impacted more on vulnerable detainees and those with little or no English. It also meant that the MPS was unable to explore the underlying reasons for the complaints (see section on strategy). The complaints monitoring system detected any pattern of complaints with a racial element, although the process of simply referring people to the front desk sometimes deterred them from making complaints in the first place.

Recommendations

5.12 More telephone lines into custody should be installed to assist ready access to staff by professionals visiting the custody suites or solicitors wishing to consult with their clients.

5.13 Discussions with court services should take place to extend court cut off times, particularly for juveniles and vulnerable detainees.

5.14 Detainees who want to make a formal complaint about their arrest or treatment in custody should be enabled to do this by the duty inspector while still in custody.

6. Healthcare

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

Clinical governance

6.1 Clinical governance arrangements for FMEs were unclear. A new contract between individual FMEs and the MPA introduced in the previous year was not specific about response times, appraisals or professional development. Contracts were not regularly monitored. Hackney BOCU did not check that annual appraisals were completed, that supervision was provided and accessed, or that continuous professional development was undertaken in line with the requirements of professional bodies. Apart from a short initial induction, the MPS had provided no mandatory training and there were no checks on whether or how FMEs updated their clinical skills. One FME described an annual face-to-face assessment by a senior medical officer appointed by the MPS. The new arrangements were unpopular with some FMEs, who felt their remunerations had reduced significantly. Custody staff said there was no obvious 'lead FME' with whom they could raise healthcare issues, which they said was a backwards step in terms of healthcare support and advice to custody staff. Since the change of contract, FMEs were no longer represented at any Hackney borough custody users meetings.

6.2 There was a lack of robust governance arrangements and healthcare policies and protocols that reflected current national guidance and healthcare legislation to provide a framework for a quality service. There was no systematic approach to monitoring or audit against standards, policy or practice and a lack of established management structures and mechanisms to address findings in good time.

6.3 There had been no training needs analysis of healthcare professionals delivering services to detainees. Some FMEs were also GPs in the community and could maintain clinical competence and professional development through other channels, but some were locum doctors where this was less structured. Custody staff had no way of finding out the qualifications or experience of any of the doctors arriving at their suite. There was only one female FME on the rota. Custody staff we spoke to did not know what procedure to follow if a female detainee specifically requested a female doctor.

6.4 Professional telephone interpreting services were available, but some FMEs did not use the service when required. One Polish detainee who had become agitated in his cell was seen by an FME who did not offer the use of an interpreter even though the service had already been used when the detainee had been booked in. The detainee became more agitated and eventually walked out of the consultation room. Custody staff said they planned to give the detainee time to calm down before getting him assessed by another FME.

6.5 Some staff were unaware who had responsibility for the overall management of the medical rooms and there did not appear to be any corporate ownership of them. All were a reasonable size and tidy, but none were particularly clean and all had a thick layer of dust on high surfaces. The flooring at Stoke Newington was not sealed and forensic sample cupboards were unlocked. The fridge lock did not have a padlock and was empty, dirty and in need of defrosting. The examination couch had a tear, but paper towel rolls were available. It was not possible to ensure that any room was forensically clean.

6.6 The yellow clinical waste bag in all two suites contained both general and clinical waste. None of the sharps boxes were dated and signed when first used and the same was true of the bins specifically for pharmaceutical items, some of which also contained syringes and needles. Clinical waste was collected regularly by an external contractor and extra collections were made on request.

6.7 Cupboards in all two suites were untidy and there were no obvious stock lists for equipment. Much of the equipment, such as electronic sphygmomanometers and glucometers, had never been used and some items were out of date. Each suite had a defibrillator behind the custody desk. All were in good working order, but there were no records of any checks even though staff clearly knew how to do this. First aid kits were sealed in large evidence bags, so the only checks were whether they were in place. We opened two at Stoke Newington and found bottles of eye wash that were six years out of date. Not all staff had up-to-date first aid and resuscitation training. We found some rooms unlocked at various times.

6.8 The deputy custody manager (DCM) was unable to ensure complete compliance with the day-to-day cleanliness and overall management of the FME room. He had not been trained in managing pharmaceutical stock or the importance of regular medicine audit. The log sheets used to administer and record medicines given to detainees were basic and open to misuse. Medications management was very poor. There was overstocking of medications and only Shoreditch had a stock list. The DCM checked and recorded stocks of Diazepam tablets and suppositories and Dihydrocodeine weekly. However, no action was taken to address any discrepancies, such as the significant discrepancy between the number of Diazepam tablets recorded and found at Stoke Newington, which we reported to the primary care trust accountable officer.

6.9 Other medications were out of date, including GTN spray at Stoke Newington, and surgical glue and antibiotics at Shoreditch. Staff said some FMEs carried their own supplies of medications to dispense to patients as they could not be sure the items they needed would be available in the custody suites. It was unclear whether similar arrangements were made by agency medical practitioners. No up-to-date drug reference books were available.

6.10 Records of medications administered from stock were not completed correctly and were not presented in a satisfactory auditable form. Arrangements for the collection of medications once ordered were poor. Medications, including Diazepam, could be left at front desks and remain there for some considerable time before collection.

Patient care

6.11 Detainees were asked on arrival about any health concerns and if they wished to see a doctor. Custody staff demonstrated a good level of care towards those with medical issues. The FMEs for Hackney BOCU also covered other areas and the north and south of the BOCU had different rotas.

6.12 Staff at both suites described very long delays between an FME being requested and actually attending. One officer said it had taken an entire shift for an FME to arrive. We met one detainee who had been taken to hospital with a head injury before arriving in custody. He had then waited several hours to be seen by an FME because the first FME took 3.5 hours to say he could not attend before the end of his shift and it was over three hours before the second FME arrived. In another incident, it had taken an FME over 3.5 hours to attend to see a man with a range of health problems and a 12 year old boy.

6.13 We asked Forensic Medical Services (FMS) to investigate these unacceptable delays, which were found to be due to the FME being required to attend to several people at Islington BCU following a planned police operation. Neither Hackney BOCU nor FMS staff had been forewarned so no contingency plans had been put in place.

6.14 Our analysis of custody records showed that the average wait for an FME to arrive was 2.5 hours. The MPS was introducing 24-hour nurse cover in all the boroughs and this provision was expected to be in place in Hackney in October 2010. Apart from inhalers, detainees were not allowed any medication, including any they had brought in with them, before seeing the FME. Given the delays, this was potentially detrimental to patient care. Medications deemed to be required after consultation were dispensed by the FME and either given immediately or clipped to the custody record to be administered later. There were arrangements for the police to obtain a prescription from a pharmacy for any medication not held in stock or carried by the FME.

6.15 Most FMEs used NSPIS to record their clinical findings, but locum doctors did not have access to it so custody staff had to transcribe their notes onto the system. Some doctors also used the book 83 (FME register), although it was not clear why this was necessary as their notes were on NSPIS. Some also kept their own notes, which they took away with them. The FME contract made clear that all clinical records made by the FME remained subject to their physical control and to the normal regulations and statutory provisions governing medical records, as well as the related principles of good medical practice in record-keeping promulgated by the General Medical Council. FMEs were responsible for their retention and secure storage. One FME said they took the medical notes home and that this was 'secure as I live on my own and no one else would have access to it'. The FME did not reveal whether the files were stored safely in the house.

Substance use

6.16 The Westminster Drug Project supported substance users at both suites and had established good relationships with custody staff. Custody staff drug tested all detainees who met the appropriate criteria and were confident that the drug workers both provided substance users with good support and were readily available for consultation. Their work, however, was hampered by the lack of interview rooms, which meant they sometimes had to communicate with clients through cell door hatches. Between October and December 2009, drug workers had assessed 174 detainees, 105 of whom had been referred to drug intervention programme services. Adults who had tested positive for class A drugs and who had allegedly committed a 'trigger offence' were referred to the drug referral worker.

6.17 Workers were available between 7am and 10pm daily. They saw detainees with drug issues at either suite and made frequent 'sweeps' of both suites. Confidentiality was guaranteed unless information passed by the detainee to the drug worker might have a detrimental effect on any other person, in which case this would be disclosed to custody staff. Everyone referred or who self-referred underwent an initial assessment. Those who lived in the borough were given an appointment to see the team within one to two weeks of the initial assessment and those living outside the borough were referred to the relevant area team. Detainees with alcohol problems were spoken to and referred to the Drugs and Alcohol Service for London. Detainees were offered only symptomatic relief, usually Dihydrocodeine medication. Drug workers were not involved in the administration of symptom relief. Young people under the age of 18 were referred to the appropriate youth offending team and there was a positive new scheme to provide diversion support to some young people who met the relevant criteria.

6.18 Workers did not supply clean needles and syringes to detainees when they were being released, but would provide details of where clean 'works' could be obtained if the detainee asked.

Mental health

6.19 There were information sharing protocols between the mental health team and police. Mental health support was provided by East London NHS Foundation Trust. The team was based at Homerton Hospital and there was an on call system for contacting the duty allied mental health professional (AMHP). Where necessary, custody staff contacted the team and an AMHP saw the detainee at the station or the detainee could be seen at the hospital. There was good access to mental health professionals through the team and there was an on call rota for psychiatrists. Relationships between custody staff and the mental health team were described as very good and all officers we spoke to said they felt well supported by the team. The team had access to paediatric psychiatrists and in-patient facilities locally if a child needed mental health assessment.

6.20 The team had delivered mental health awareness training to 308 police officers, which was commendable. Service users were involved with the training and this was said to be very beneficial to the training programme.

6.21 A police liaison officer who was also a registered mental nurse was the link between the custody suites and the team from Homerton Hospital and other community mental health teams. The system worked well and the two parties met regularly.

6.22 Custody suites were not used for people detained under the Mental Health Act 1983 Section 136. Such potential cases were taken to a designated mental health suite at Homerton Hospital. In 2009, 160 detainees had been held under Section 136, which had been a year on year increase, but specific final numbers were not available at the time of the inspection. The Section 136 suite at the hospital was very clean and provided a calm and peaceful area where detainees could be managed. The suite was adjacent to one of the wards in the medium secure unit and was permanently staffed by one of the ward staff.

Recommendations

6.23 Female detainees should be able to see a female doctor on request.

6.24 Clear infection control procedures should be introduced and should include cleaning schedules that should be adhered to and monitored.

6.25 There should be contingencies in place in the event of any planned police operation that may reduce the availability of the FME, so that all detainees are seen expeditiously.

6.26 Detainees should continue to receive pre-existing prescribed medication for any clinical condition, and receive medication to provide relief for drug and alcohol withdrawal symptoms if needed.

6.27 All clinical records should be stored in accordance with the Data Protection Act 1998 and Caldicott guidance.

6.28 Injecting drug users released into the community should be offered clean needles and syringes by drug workers.

Housekeeping points

6.29 Excess pharmacy items should be returned to the provider.

6.30 The 'front desk' should notify the responsible officer when pharmaceutical items are received at the station.

6.31 Healthcare professionals should have access to up-to-date drug reference books.

6.32 Doctors should not use the book 83 to record their clinical findings.

6.33 FME rooms should be locked at all times.

Good practice

6.34 *There were excellent arrangements to support detainees with mental health problems in terms of communications, relationships, police officers, staff training and section 136.*

7. Summary of recommendations

The following is a listing of recommendations, housekeeping points and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Main recommendations

To the Metropolitan Police Service

7.1 All staff and other employees who operate within the custody environment should not be deployed into custody suites until they have been given custody specific training, which includes training in how to use the NSPIS custody system. (2.22)

7.2 Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults in custody. (2.23)

7.3 All PACE DNA samples should be submitted to the national DNA database or destroyed as soon as practicable, if no longer required. (2.24)

7.4 Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners. (2.25)

7.5 Managers should ensure that all custody staff and healthcare professionals adhere to the newly introduced guidelines for the security, management, administration and disposal of drugs and medicines in custody. The discovery of missing medicines, particularly controlled drugs, should immediately be notified up the chain of command and to the PCT accountable officer. (2.26)

Recommendations

Strategy

7.6 Custody refresher training should be provided to all staff who work within the custody environment as a matter of course. (3.14)

7.7 The use of force should be monitored locally and at a force-wide level, for example by ethnicity, location and officer involved. (3.15)

Treatment and conditions

7.8 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.20)

7.9 A range of materials for the observance of all major faiths should be available at Shoreditch. (4.21)

7.10 All staff should carry anti-ligature knives. (4.22)

7.11 All cells and detainee areas should be clean, fit for purpose and free of ligature points. (4.23)

7.12 A force-wide policy to address graffiti should be developed and implemented. (4.24)

7.13 Subject to individual needs assessment, nicotine replacement should be available to detainees. (4.25)

7.14 Staff working in the custody suite should be familiar with fire safety arrangements. (4.26)

7.15 Toilet paper should be provided routinely. (4.27)

7.16 Detainees held overnight and those who are dirty should be offered a shower and clean towels. (4.28)

7.17 Wherever possible, detainees held for longer periods should be offered outdoor exercise and visits. (4.29)

Individual rights

7.18 More telephone lines into custody should be installed to assist ready access to staff by professionals visiting the custody suites or solicitors wishing to consult with their clients. (5.12)

7.19 Discussions with court services should take place to extend court cut off times, particularly for juveniles and vulnerable detainees. (5.13)

7.20 Detainees who want to make a formal complaint about their arrest or treatment in custody should be enabled to do this by the duty inspector while still in custody. (5.14)

Healthcare

7.21 Female detainees should be able to see a female doctor on request. (6.23)

7.22 Clear infection control procedures should be introduced and should include cleaning schedules that should be adhered to and monitored. (6.24)

7.23 There should be contingencies in place in the event of any planned police operation that may reduce the availability of the FME, so that all detainees are seen expeditiously. (6.25)

7.24 Detainees should continue to receive pre-existing prescribed medication for any clinical condition, and receive medication to provide relief for drug and alcohol withdrawal symptoms if needed. (6.26)

7.25 All clinical records should be stored in accordance with the Data Protection Act 1998 and Caldicott guidance. (6.27)

7.26 Injecting drug users released into the community should be offered clean needles and syringes by drug workers. (6.28)

Housekeeping points

Treatment and conditions

7.27 Mattresses and pillows should be wiped down after use. (4.30)

7.28 Dirty blankets should be stored appropriately. (4.31)

7.29 Detainees whose clothing is seized should be given suitable alternative clothing, including underwear. (4.32)

7.30 Detainees should be offered a choice of all the available options of microwave meals and all should be in date. (4.33)

7.31 A cordless telephone should be provided to allow detainees to consult solicitors in private. (4.34)

7.32 Detainees should have access to suitable reading material. (4.35)

Healthcare

7.33 Excess pharmacy items should be returned to the provider. (6.29)

7.34 The 'front desk' should notify the responsible officer when pharmaceutical items are received at the station. (6.30)

7.35 Healthcare professionals should have access to up-to-date drug reference books. (6.31)

7.36 Doctors should not use the book 83 to record their clinical findings. (6.32)

7.37 FME rooms should be locked at all times. (6.33)

Good practice

Healthcare

7.38 *There were excellent arrangements to support detainees with mental health problems in terms of communications, relationships, police officers, staff training and section 136.* (6.34)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Fiona Shearlaw	HMIC inspector
Paddy Craig	HMIC inspector
Elizabeth Tysoe	HMIP healthcare inspector
Bridget McEvilly	HMIP healthcare inspector
Huw Jenkins	CQC inspector
Catherine Nichols	HMIP researcher
Olayinka Macauley	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Hackney Borough police custody cells, a sample of the custody records of detainees held between 3 and 8 January 2010 were analysed. Custody records were held electronically on NSPIS. A total sample of 31 records were analysed from across the Hackney area:

Custody suite	Number of records analysed
Stoke Newington	19
Shoreditch	12
Total	31

The analysis looked at the level of care and access to services such as showers, exercise and telephone calls detainees received. Any additional information of note was also recorded.

Demographic information

- Five (16%) of the detainees were female and 26 were male.
- Two people (6%) under the age of 17 were included in the sample.
- Seventeen (55%) detainees were from a black or minority ethnic background.
- One detainee was processed for immigration purposes, but there was no recorded contact with UKBA on his custody record and he was subsequently released.
- Twenty (65%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. Three (10%) had been held for more than 24 hours and 14 (45%) were held longer than 12 hours, but less than 24.
- Five (16%) people had indications of self-harm or suicide.
- One (3%) person had learning difficulties and a further seven (23%) had mental health problems.
- Eleven (35%) entered custody intoxicated, with four (13%) people seeing a drugs worker while they were in custody.
- Twenty-two (71%) detainees returned home after release, eight (26%) went to court and one (3%) was transferred to a hospital under social services care.

Removal of clothing

Two detainees had had clothing removed from them:

- One detainee had had their outer clothing removed for safety purposes as she was at risk of harming herself.
- One detainee had had all clothes removed and had been given a paper suit as his clothes had blood splatter on them. He was given only a tracksuit to wear 30 hours later as he was due to attend court.

Young people

Both young people were 15 year old girls and had their parents acting as appropriate adults, both during their interview and the reading of their rights. This was not clearly indicated on the records when logs mentioned interviews, but was recorded elsewhere in the record.

Interpreters

Three (10%) detainees in our sample could not understand English and required an interpreter. One was booked in using a professional telephone interpreting service, but this was not clearly recorded. One had an interpreter present who facilitated calls, the interview and risk assessment process. The third detainee, who spoke Russian, had an interpreter arrive 14 hours after he was booked in and no evidence of a re-reading of his rights was indicated and no interview conducted so it was unclear what the interpreter was translating.

Inspector reviews

Inspector reviews were held in line with requirements. None of the reviews were conducted at a delayed time, but one was held remotely due to other operational commitments.

Services

- All detainees had been asked whether they wanted someone informed of their arrest. Ten (32%) detainees had made additional telephone calls themselves.
- All detainees had been asked if they wanted a solicitor. Twelve (39%) detainees had requested a solicitor and spoken/seen either their solicitor or a duty solicitor. A further two (6%) detainees requested a solicitor, but left police custody before they had received legal representation, both attending court.
- No detainees shared a cell while in custody.
- Thirteen (42%) detainees had seen a FME. One detainee never saw an FME after waiting two hours 54 minutes, when the FME was cancelled as a social worker from Mind attended to act as the detainee's appropriate adult. The longest wait was two hours 20 minutes.
- For one detainee transferred to a hospital, a mental health team and social worker quickly came to asses her. Her assessment was through the door to the cell.
- Nineteen (61%) detainees had eaten at least one meal while in custody. Nine (29%) had had no food and not been offered food. Three detainees had been offered food, but had refused. There were some examples of detainees being released in the morning having been held overnight with no offer of breakfast recorded, or arriving just after dinnertime and again an evening meal not being recorded as even offered. One detainee was held for 20 hours and another for 14 hours without the offer of food.
- No detainees had received a shower.
- No detainees had received outside exercise.
- No detainees had been provided with reading materials.
- Sixteen (52%) of detainees were strip searched.

Additional points of note

- NSPIS automatically promoted staff to check whether women arriving into custody wanted to speak to a female member of staff in private.
- The foreign nationals rights procedure was conducted seven out of the nine with foreign national detainees.
- The pre-release risk assessments were scantly completed with little to no risk information or planning recorded.

Appendix III: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Hackney, 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 5 January 2010. A list of potential respondents to have passed through Shoreditch or Stoke Newington police stations was created, listing all those who had arrived from Thames Magistrates court within the past month.

Selecting the sample

In total, 93 respondents were approached. Fifty-two reported either being held in police stations outside Hackney or outside the one-month time limit, and four could not speak English so it was impossible to determine which police station they had been in. On the day, the questionnaire was offered to 37 respondents. There were four refusals, one questionnaire was returned blank and there were two non-returns. All those sampled had been in custody within the last month.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, two respondents were interviewed.

Methodology

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

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

- 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
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Response rates

In total, 30 (81%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses are 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 19 police areas since April 2008.

In the comparator document, statistical significance is used to indicate whether there is a real difference between the figures, i.e. 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 has been weighted for comparison purposes.

Police custody survey

Section 1: About you

Q2 **What police station were you last held at?**

Stoke Newington - 24; Shoreditch - 4; Not Recorded - 2

Q3 **What type of detainee were you?**

Police detainee	24 (86%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	1 (4%)
Immigration detainee	1 (4%)
I don't know	2 (7%)

Q4 **How old are you?**

16 years or younger	0 (0%)	*40-49 years*	9 (30%)
17-21 years	1 (3%)	*50-59 years*	2 (7%)
22-29 years	10 (33%)	*60 years or older*	1 (3%)
30-39 years	7 (23%)		

Q5 **Are you:**

Male	30 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 **What is your ethnic origin?**

White - British	7 (23%)
White - Irish	1 (3%)
White - Other	3 (10%)
Black or Black British - Caribbean	7 (23%)
Black or Black British - African	3 (10%)
Black or Black British - Other	2 (7%)
Asian or Asian British - Indian	1 (3%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - Other	2 (7%)
Mixed Heritage - White and Black Caribbean	2 (7%)
Mixed Heritage - White and Black African	0 (0%)
Mixed Heritage- White and Asian	1 (3%)
Mixed Heritage - Other	1 (3%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

Please specify:

Q7 **Are you a foreign national** (i.e. you do not hold a British passport, or you are not eligible for one)**?**

Yes	5 (18%)
No	23 (82%)

Q8 What, if any, would you classify as your religious group?

None	8 (27%)
Church of England	10 (33%)
Catholic	3 (10%)
Protestant	0 (0%)
Other Christian denomination	1 (3%)
Buddhist	1 (3%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	7 (23%)
Sikh	0 (0%)
Any other religion, please specify	

Q9 How would you describe your sexual orientation?

Straight/heterosexual	29 (100%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	0 (0%)
Other (please specify):	

Q10 Do you consider yourself to have a disability?

Yes	3 (10%)
No	25 (86%)
Don't know	1 (3%)

Q11 Have you ever been held in police custody before?

Yes	29 (97%)
No	1 (3%)

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

One hour or less	0 (0%)
More than one hour, but less than six hours	1 (3%)
More than six hours, but less than 12 hours	0 (0%)
More than 12 hours, but less than 24 hours	6 (20%)
More than 24 hours, but less than 48 hours (two days)	9 (30%)
More than 48 hours (two days), but less than 72 hours (three days)	9 (30%)
72 hours (three days) or more	5 (17%)

Q13 Were you given information about your arrest and your entitlements when you arrived there?

Yes	19 (66%)
No	7 (24%)
Don't know/can't remember	3 (10%)

Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')**?**

Yes	16 (53%)
No	10 (33%)
I don't know what this is/I don't remember	4 (13%)

Q15 **If your clothes were taken away, were you offered different clothing to wear?**

My clothes were not taken	22 (73%)
I was offered a tracksuit to wear	1 (3%)
I was offered an evidence suit to wear	5 (17%)
I was offered a blanket	2 (7%)

Q16 **Could you use a toilet when you needed to?**

Yes	28 (93%)
No	1 (3%)
Don't know	1 (3%)

Q17 **If you have used the toilet there, were these things provided?**

	Yes	*No*
Toilet paper	11 (38%)	18 (62%)

Other (please specify):

Q18 **Did you share a cell at the police station?**

Yes	0 (0%)
No	30 (100%)

Q19 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	8 (28%)	11 (38%)	10 (34%)
Ventilation/air Quality	9 (35%)	8 (31%)	9 (35%)
Temperature	5 (19%)	9 (33%)	13 (48%)
Lighting	11 (39%)	8 (29%)	9 (32%)

Q20 **Was there any graffiti in your cell when you arrived?**

Yes	19 (66%)
No	10 (34%)

Q21 **Did staff explain to you the correct use of the cell bell?**

Yes	2 (7%)
No	26 (93%)

Q22 **Were you held overnight?**

Yes	28 (97%)
No	1 (3%)

Q23 **If you were held overnight, which items of clean bedding were you given?**

Not held overnight	1 (3%)
Pillow	8 (23%)
Blanket	17 (49%)
Nothing	9 (26%)

Q24 **Were you offered a shower at the police station?**

Yes	1 (4%)
No	27 (96%)

Q25 Were you offered any period of outside exercise whilst there?

Yes	0 (0%)
No	29 (100%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	23 (82%)	5 (18%)
Drink?	20 (87%)	3 (13%)

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

I did not have any food or drink	1 (3%)
Yes	13 (45%)
No	15 (52%)

Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?

I do not smoke	2 (7%)
I was allowed to smoke	2 (7%)
I was not offered anything to cope with not smoking	25 (86%)
I was offered nicotine gum	0 (0%)
I was offered nicotine patches	0 (0%)
I was offered nicotine lozenges	0 (0%)

Q29 Were you offered anything to read?

Yes	2 (7%)
No	27 (93%)

Q30 Was someone informed of your arrest?

Yes	11 (38%)
No	12 (41%)
I don't know	1 (3%)
I didn't want to inform anyone	5 (17%)

Q31 Were you offered a free telephone call?

Yes	13 (45%)
No	16 (55%)

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

My phone call was not denied	16 (62%)
Yes	2 (8%)
No	8 (31%)

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

	Yes	*No*
Who was taking care of your children	2 (14%)	12 (86%)
Contacting your partner, relative or friend	15 (63%)	9 (38%)
Contacting your employer	5 (33%)	10 (67%)
Where you were going once released	3 (23%)	10 (77%)

Q34 Were you interviewed by police officials about your case?

Yes	25 (89%)
No	3 (11%) If No, go to Q36

Q35 **Were any of the following people present when you were interviewed?**

	Yes	*No*	*Not needed*
Solicitor	19 (76%)	4 (16%)	2 (8%)
Appropriate adult	0 (0%)	6 (50%)	6 (50%)
Interpreter	0 (0%)	4 (33%)	8 (67%)

Q36 **How long did you have to wait for your solicitor?**

I did not requested a solicitor	7 (25%)
Two hours or less	3 (11%)
Over two hours but less than four hours	1 (4%)
Four hours or more	17 (61%)

Q37 **Were you officially charged?**

Yes	27 (96%)
No	1 (4%)
Don't Know	0 (0%)

Q38 **How long were you in police custody *after* being charged?**

I have not been charged yet	1 (4%)
One hour or less	1 (4%)
More than one hour, but less than six hours	1 (4%)
More than six hours, but less than 12 hours	8 (29%)
12 hours or more	17 (61%)

Section 3: Safety

Q40 **Did you feel safe there?**

Yes	16 (55%)
No	13 (45%)

Q41 **Had another detainee or a member of staff victimised (insulted or assaulted) you there?**

Yes	10 (37%)
No	17 (63%)

Q42 **If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)**

I have not been victimised	17 (61%)	*Because of your crime*	3 (11%)
Insulting remarks (about you, your family or friends)	3 (11%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	1 (4%)	*Because you have a disability*	1 (4%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	3 (11%)		

Please describe:

Q43 **Were you handcuffed or restrained whilst in the police custody suite?**

Yes	11 (41%)
No	16 (59%)

Q44 **Were you injured whilst in police custody, in a way that you feel was not your fault?**

Yes 6 (22%)

No 21 (78%)

Q45 **Were you told how to make a complaint about your treatment here if you needed to?**

Yes 5 (19%)

No 22 (81%)

Section 4: Healthcare

Q47 **When you were in police custody were you on any medication?**

Yes 11 (37%)

No 19 (63%)

Q48 **Were you able to continue taking your medication while there?**

Not taking medication 19 (63%)

Yes 5 (17%)

No 6 (20%)

Q49 **Did someone explain your entitlements to see a healthcare professional if you needed to?**

Yes 9 (32%)

No 16 (57%)

Don't know 3 (11%)

Q50 **Were you seen by the following healthcare professionals during your time there?**

	Yes	*No*
Doctor	19 (63%)	11 (37%)
Nurse	1 (6%)	16 (94%)
Paramedic	0 (0%)	17 (100%)
Psychiatrist	0 (0%)	17 (100%)

Q51 **Were you able to see a healthcare professional of your own gender?**

Yes 8 (29%)

No 13 (46%)

Don't know 7 (25%)

Q52 **Did you have any drug or alcohol problems?**

Yes 12 (41%)

No 17 (59%)

Q53 **Did you see, or were offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems 17 (61%)

Yes 6 (21%)

No 5 (18%)

Q54 **Were you offered relief or medication for your immediate symptoms?**

I didn't have any drug/alcohol problems 17 (61%)

Yes 2 (7%)

No 9 (32%)

Q55 **Please rate the quality of your healthcare while in police custody:**

	I was not seen by health -care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of Healthcare	10 (33%)	1 (3%)	5 (17%)	5 (17%)	4 (13%)	5 (17%)

Q56 **Did you have any specific <u>physical</u> healthcare needs?**

No 22 (76%)

Yes 7 (24%)

Please specify:

Q57 **Did you have any specific <u>mental</u> healthcare needs?**

No 25 (89%)

Yes 3 (11%)

Please specify: