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

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by

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1. Introduction

This report is one in a series relating to inspections of police custody carried out jointly by 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 health care.

This inspection was of the Wembley and Kilburn custody suites in the London Borough of Brent, within the Metropolitan Police Service. Strategic oversight of custody throughout the Metropolitan Police Service is carried out centrally by the Emerald Territorial Policing team, with a view to ensuring consistent practice. There was also a clear management structure overseeing custody within the borough and good relationships with the Independent Custody Visitors (ICVs), with any issues they raised responded to positively by local managers.

Observed relationships between staff and detainees were professional and risk assessments were thorough, however some officers deployed in custody had not received accredited training. As we have noted frequently in these reports, there was insufficient local and strategic monitoring of trends in the use of force, and there was a need to make better use of national and local good practice, and 'learning the lessons' information. There was some good partnership working, including with the UK Border Agency and health care providers.

While most detainees reported feeling safe, some cells had ligature points as well as requiring better presentation. There was variable awareness among staff of the specific vulnerabilities of women and juveniles in custody. There were also problems with the degree of privacy afforded to detainees while being booked in.

The requirements of the Police and Criminal Evidence Act (PACE) were adhered to. However, this meant that, in keeping with national practice under PACE provisions, 17 year olds were excluded from automatic entitlement to the appropriate adult service – a situation which continues to cause us concern nationally. The management of forensic samples was satisfactory. Detainees were not generally allowed to make a formal complaint while still in custody, despite management expectations to the contrary.

Health care provision was generally good, supported by effective substance abuse and mental health services. However, the monitoring and governance of the health care contract required improvement, and the inspection identified some deficiencies in checking the qualification and training of forensic medical examiners (FMEs), records management and FME response times.

This is a largely positive report. It does, however, raise some issues, including the monitoring of the use of force, facilitating complaints and the oversight of health service provision. We

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

hope that its recommendations will be helpful to the Metropolitan Police Service and the borough commander in continuing to improve custodial conditions and treatment in Brent.

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HM Chief Inspector of Constabulary

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July 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, Operation Safeguard or immigration detention. The remaining custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.

2.3 This announced inspection was conducted at Wembley and Kilburn, which are the custody suites in the London Borough of Brent. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites.

2.4 A survey of prisoners at HMP Wormwood Scrubs who had formerly been detained at custody suites in the borough was conducted by an HM Inspectorate of Prisons researcher and inspector to obtain additional evidence (see Appendix II).

2.5 Brent borough operational command unit (BOCU) was not an Operation Safeguard[3] site, although Kilburn was used as a charge centre for major operations such as the Notting Hill Carnival. Charge facilities for sporting events at Wembley were split between Wembley and Kilburn depending on the number of cells required by the MPS central operations unit. Wembley had 21 cells and four detention rooms and Kilburn had 15 cells and two detention rooms. They were open 24 hours a day and held adults and juveniles. The suites had received 13,119 detainees between March 2009 and April 2010 (8,519 at Wembley and 4,600 at Kilburn).

Strategic overview

2.6 The MPS custody directorate within the 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. There was an active local independent custody visitors (ICV) scheme at Brent and issues raised were responded to positively by the BOCU.

2.7 The custody estate in Brent was well served in terms of capacity. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and therefore rested with the BOCU commander, who was a chief superintendent. He and his

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

[3] Operation Safeguard relates to the use of police cells for overspill prisoners from HM prisons

senior management team visited the custody suites every day and enquired into individual detainee's cases. There was a clear management structure overseeing custody in the borough and regular forums where custody issues were discussed. The quality of dip sampling of custody records was generally poor. There was a lack of management information to support the strategic management of provision.

2.8 There were permanent and temporary custody sergeants at both suites, although Wembley benefited from having mostly permanent custody sergeants except at night. Sergeants were supported by a small number of dedicated detention officers (DDOs), who were permanent custody staff, and police constable (PC) gaolers, who were not permanent and had not benefited from custody specific training. Some PC gaolers could not input onto NSPIS, which impacted on the quality and value of entries.

2.9 There was some good partnership work and the BOCU commander chaired the local criminal justice board. There was no evidence that Independent Police Complaints Commission (IPCC) 'Learning the Lessons' newsletters or other good practice information was circulated to custody staff. There was no BOCU-wide collation of use of force to enable trends and patterns to be analysed.

Treatment and conditions

2.10 Relationships between staff and detainees were respectful and calm at Wembley, but staff at Kilburn were more distant. Booking in desks offered little privacy and telephone calls could be overheard, particularly at Kilburn. The Wembley suite was busy, but the separate area for bail returns helped ease the pressure. Women were treated much the same as men, but staff were more aware of the vulnerability and needs of juvenile detainees. There were no adapted cells for detainees with disabilities and no hearing loops. Materials for observing major faiths were available, but some Muslim prisoners said they had not been able to wash before prayers.

2.11 Detainees were mostly positive about feeling safe in custody. All were thoroughly risk assessed on arrival. Procedures for dealing with those at risk were appropriate at Wembley, but monitoring at Kilburn was not always taking place on time and PC gaolers there did not have a sufficiently detailed knowledge of the detainees in their care. Relevant information was properly shared at handovers between shifts.

2.12 Staff were appropriately trained in use of force techniques and, despite limited monitoring, records indicated that force was not overused, but there were no protocols for use for Tasers in custody suites. We saw de-escalation used appropriately at Wembley.

2.13 Wembley was generally clean and well maintained, but cells at Kilburn contained a lot of graffiti and the two detention rooms there smelled strongly of urine. Cells were not checked between uses and mattresses and pillows were not routinely wiped down when a cell was vacated. We found several ligature points at Kilburn, but managers took immediate action when these were pointed out to them. Fire alarm and evacuation procedures were tested regularly. Cell bells worked and were usually responded to fairly promptly. Both suites had showers, but detainees were not routinely offer the chance to shower and those at Wembley were small and ran cold. Only a limited range of replacement clothing was provided and no underwear.

2.14 The food provided was good, but not checked for temperature. Detainees were rarely offered time in the small exercise yards and visits were authorised only in exception circumstances.

Individual rights

2.15 Custody sergeants checked that arrest and detention were appropriate. Kilburn was not used as a place of safety for children, but Wembley had occasionally been used as such. Access to professional telephone interpreters was reasonable and the rights and entitlements were available in a range of languages. There were good links with the UK Border Agency (UKBA), but some immigration detainees could still be held for up to four days. Detainees with dependents were given practical help and telephone calls were facilitated when necessary. Pre-release risk assessments were carried out and we saw one woman vulnerable to domestic violence given good support, but this was not consistently the case.

2.16 PACE was adhered to and posters advertised detainees' right to free legal advice, but neither suite offered complete privacy when making calls to solicitors. Appropriate adult provision was adequate, but police adhered to the PACE definition of a child so 17 year olds were not routinely provided with an appropriate adult. The management of DNA and forensic samples was mostly good. Detainees who were charged were promptly put before the courts, but there were no video link facilities.

2.17 Detainees were not told how to make a complaint. Senior managers expected complaints to be dealt with promptly and, where possible, by the duty inspector, but staff were still advising detainees to complain after release. IPCC complaint forms were available.

Health care

2.18 Health service provision was reasonable and the relationship between custody staff and FMEs generally good. Governance arrangements for health care were managed centrally by the MPS and health care delivered by individual FMEs contracted in by Forensic Health Services. Clinical governance remained the responsibility of individual FMEs, which was unsatisfactory.

2.19 The FME rooms were clean and offered good privacy, but examination couches were not screened. The management of medications was reasonable, but there were no medicine management policies or procedures. There was some overstocking and incorrect auditing and there were no arrangements to ensure that detainees' own medication was securely locked away.

2.20 Custody staff and FMEs were concerned about protracted response times, which records indicated could be up to three hours. This also impacted on detainees with mental health issues, who needed an FME referral for a mental health assessment. Custody staff did not know what the expected response times were and did not routinely report these to allow monitoring. Emergency medical services were used in urgent cases.

2.21 Drug and alcohol services were good and workers from the Westminster Drug Project were well integrated into the work in the custody suites. They offered on site and out-of-hours services, including referral to rapid prescribing and signposting to services in the community around the country. There was a link worker with all local prisons.

2.22 Detainees with mental health issues were well managed, with referrals to the crisis team when required. There was good provision at Park Royal mental health unit for section 136 patients.

Main recommendations

2.23 Staff and other employees who operate in the custody environment should not be deployed in custody suites until they have received custody-specific training, including on how to use the NSPIS custody system.

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

2.25 All cells should be suitable for detaining individuals and clear of graffiti, odour and ligature points.

2.26 Appropriate adults should be available 24 hours a day to support juveniles aged 17 and under and vulnerable adults in custody.

2.27 Staff should adhere to the MPS guidelines for the management of drugs and medicines in custody. Missing medicines, particularly controlled drugs, should immediately be notified to the primary care trust 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 MPS had a custody directorate led by a commander within territorial policing headquarters. Day-to-day management of the custody directorate was delivered by a detective superintendent. There was an internal inspection function, with mechanisms to ensure compliance with inspection findings. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs. Accountability therefore rested with the BOCU commander, who was a chief superintendent. There was no MPA member who took the lead for custody, but a MPA official managed the Independent Custody Visitor (ICV) scheme and had lead responsibility for reporting on custody issues.

3.2 The territorial policing commander was the chief officer lead on custody for the MPS. The custody directorate had an inspection function for audit and compliance, health and safety and the implementation of SDHP guidance. The commander sat on the programme board for SDHP and was clearly focused on ensuring emphasis on 'professionalising custody'. He was also preparing to introduce integrated prosecution teams (IPTs) and 'virtual courts' through video links[4].

3.3 Policies were signed off at a strategic command level in the MPS and the custody directorate provided SOPs that supported delivery of force policies by custody suites in each London BOCU. The SOPs covered a broad spectrum, including use of police custody, use of closed-circuit television (CCTV) and guidance to custody staff on the supervision of detainees. They were designed to help BOCUs deliver consistent levels of service.

3.4 The MPS's asset management plan had stalled due to the wider economic situation, which had led to a 'rephasing' of the building plans prioritised by most pressing need. The current capacity of the custody estate in Brent was adequate to meet demand and there were no immediate plans for any major improvements or capacity building. However, Wembley was a busy custody suite and Kilburn was tired and showing its age. Maintenance of the Wembley and Kilburn custody suites could usually be carried out when facilities were open.

3.5 A full-time inspector was custody suite manager for both sites, but was also called on to fulfil duty inspector shifts and some other ad hoc duties. Full-time permanent police sergeants (custody officers) were 'posted' into the custody role, although sergeants from the patrol shifts were used for night shifts. There were eight designated detention officers (DDOs). This was due to increase to 34 as part of phase three of Project Herald (workforce modernisation), at which point the BOCU would no longer need to use untrained police constable (PC) gaolers to augment the DDOs. Apart from PC gaolers, all custody staff had received nationally approved custody training delivered corporately before being deployed in the custody suite. Custody officers had also received annual refresher training. (See main recommendations.)

[4] The integration of police and CPS staff into joint teams and the establishment of video links between custody suites and courts are pilot initiatives to reduce delays and inefficiencies in the CJS.

3.6 Two sergeants were responsible for a well-run bail to return (BTR) office at Wembley, which eased the pressure on the custody suite by keeping detainees, their families and solicitors out of the facility.

3.7 The MPS had recruited teams of nurses for six stations to complement the level of health care provided by its doctors. The aim was to recruit 200 nurses by 2012 to ensure that each BOCU had a nurse on duty 24 hours a day. They were not yet available at Brent, but were expected to arrive in due course as part of the rollout of Project Herald.

3.8 The BOCU commander chaired local criminal justice board (LCJB) meetings. There was no UK Border Agency (UKBA) link at LCJB level and the BOCU commander said the UKBA had no visible presence in the custody suites despite being offered office space. Local defence solicitors had been invited to the previous three LCJB meetings, but none had attended. The BOCU commander hoped to make progress in this area. Relationships with the Crown Prosecution Service (CPS) were good, with productive case management processes and escalation routes when there were differences of opinion on how criminal cases should be progressed. The recent introduction of a Borough Crown Prosecutor had produced a very positive impact and the BOCU commander met the Chief Crown Prosecutor every month.

3.9 There was an MPA official who managed the ICV scheme, which was an independent oversight mechanism. ICVs visited the custody suites regularly and were focused on prisoner welfare. Feedback reports were produced after each visit and the MPS put together a summary report for quarterly ICV panel meetings. Issues of concern identified by ICVs were addressed immediately by the custody sergeant or more longer-term issues by the custody manager, with progress reports supplied to ICVs. ICVs reported good relationships with custody staff and were particularly impressed by the support offered to detainees by DDOs and to the ICVs themselves by the chief inspector and the custody manager. Staff were receptive to issues raised and ICVs were invited in for high profile operations with the potential to involve large numbers of arrests and detainees.

3.10 The BOCU commander and senior management team (SMT) visited the custody suites every day and enquired into individual detainee's cases. The SMT lead for custody was a detective superintendent. A new support staff manager had recently been appointed custody and criminal justice manager and met weekly with the superintendent to discuss custody and criminal justice issues. They held quarterly criminal justice meetings with the BOCU commander and custody was a standing item on the wider criminal justice agenda. Detainee and custody issues were raised at daily management meetings and weekly SMT meetings.

3.11 Custody officers actively used BOCU resources to ensure detainees deemed high risk were suitably supervised, even though this clearly impacted on the availability of police officers for other duties. Some of the quality assurance mechanisms were insufficiently thorough. The custody suite manager dip-sampled records weekly, but this comprised a cursory read through, was not cross-referenced with CCTV footage and did not involve a large enough representative selection of records.

3.12 The MPS could not provide management information from within the NSPIS custody system, even though it was possible to extract this using the NSPIS 'business objects' reporting model. Consequently, individual BOCUs could not get relevant and timely management information to support strategic planning and staffing models and inform performance around investigative decisions.

3.13 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating

successful interventions and near misses. Although the custody directorate also circulated the IPCC 'Learning the Lessons' newsletters, there was no evidence that these or other good practice information were circulated to custody staff.

3.14 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. Therefore, there was no management information accessible from a local or force-wide perspective. (See main recommendations.)

Recommendations

3.15 The MPA should allocate one authority member as lead for custody.

3.16 Custody records should be routinely dip-sampled and compared with contemporaneous CCTV footage. The number checked each time should ensure a meaningful representative sample of detainees held in custody and include examples of all custody officers working in this area.

3.17 The MPS should urgently address the force-wide and borough shortcomings in terms of extracting management information from NSPIS to focus critical thinking, including the structural processes and IT deficiencies that inhibit this.

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 Vans used to transport detainees were clean, relatively spacious and in good condition.

4.2 The booking in process at Wembley was respectful and detainees were often addressed by their first names. The area was busy, but staff maintained a calm and controlled environment. We saw up to 10 people, including juveniles, waiting to be booked in. They had long waits in often unsuitable waiting areas, although they could use a toilet. We did not see anyone booked in at Kilburn.

4.3 The booking in desks were an appropriate height, but offered little privacy. Telephone calls at Wembley were made in an area slightly away from the desk, but the hood was not very effective. Wembley had a separate area for bail returns, which helped reduce the number of people in an otherwise busy custody suite. Bail returns at Kilburn were dealt with at the booking in desk. The telephone at Kilburn was also slightly away from the desk, but had no hood at all and was situated next to a seating area.

4.4 Female detainees were mostly treated the same as male detainees and some staff showed little understanding of the impact of custody on different groups. Front line custodial staff at Kilburn were particularly oblivious to the specific needs of individuals. Women and girls were, at least, offered the opportunity to speak to a female member of staff. Juveniles were usually put in detention rooms closer to the booking in desk where they could be observed more easily. Staff at Wembley demonstrated some awareness of their different needs and parents we spoke to said they were content with how their children had been treated.

4.5 There were no adapted facilities for detainees with disabilities and no hearing loops. Staff said each detainee's needs were assessed individually and gave examples of those who had been able to keep mobility aids. One detainee with a physical disability was treated with appropriate care at Wembley, but the cell they were put in had a low plinth and staff therefore had to help them sit down and stand up. There was a range of materials to allow detainees to observe their faith. All cells were marked with the direction of prayer for Muslims and staff said detainees could wash at the sinks or using a cup of water before prayers, but detainees said they had not been able to wash between eating and praying.

4.6 Notes in custody records were mostly respectful, but one inappropriately described a detainee as 'unkempt and smelled, like some homeless people do'.

Safety

4.7 Detainees we spoke to were mostly positive about feeling safe in custody. All were subject to a comprehensive risk assessment on arrival, but these did not always consider how young people, women and those new to custody might be particularly vulnerable. There were appropriate arrangements for monitoring those at risk and we saw one detainee at Wembley with a medical condition allowed to sit on a bench by the booking in desk rather than put in a

cell. Levels of monitoring set by the risk assessment were adhered to and we saw some positive staff engagement with detainees at Wembley. At Kilburn, monitoring, including night observation, was not always carried out within the timescales required and one detainee assessed to need 30-minute checks was left for over an hour. There did not appear to be any quality assurance mechanism to identify and address this.

4.8 No detainees shared a cell. CCTV monitoring was used appropriately for detainees judged at higher risk, but it was not used as a substitute for personal interaction. Items such as belts and shoelaces were not automatically removed from detainees considered a low risk, which was appropriate. All PC gaolers and DDOs in the cell area carried keys and an anti-ligature tool and all understood the importance of rousing detainees. Safety information was appropriately shared at custody sergeant handovers. PC gaolers at Wembley were aware of the circumstances, risks and concerns of detainees in their care, but this was less clearly the case at Kilburn.

4.9 Custody sergeants were given advance warning before a violent detainee arrived and took appropriate action to manage the situation.

Use of force

4.10 New arrivals were given a rub-down search and handcuffs were removed as soon as possible. Staff were appropriately trained in use of force techniques, with refresher training in relevant subjects such as de-escalation twice a year. They understood the need for proportionality. We saw one angry detainee at Wembley peacefully removed to calm down away from the booking in desk, where a young detainee was also being booked in. Detainee interviews and custody record analysis did not indicate that force was overused, but local monitoring was limited. Detainees subject to force were not routinely seen by a doctor unless there were any visible signs of injury and depending on the type of force used. Staff said doctors requested following use of force had sometimes refused to attend.

4.11 PC gaolers carried CS spray. We were told this would not be used in custody and custody sergeants did not carry it. We were also told that Tasers would not be used in custody, but records from April 2010 stated that a detainee had been 'tasered and restrained' following acts of self-harm and aggression towards staff. A review of this incident did not reveal significant concerns about the use of force, although the detainee concerned was at risk of harming himself and staff did not have protocols for the use of Tasers in the confined area of the custody suite.

Physical conditions

4.12 Cells and detention rooms at Wembley were generally clean and well maintained, but some toilets were dirty. There was a lot of graffiti on the varnished plinths at Kilburn, some gang-related and some offensive about police staff. There was a strong smell of urine in the two detention rooms at Kilburn. In our survey, 27% of respondents, against a comparator of 13%, said cell temperatures were good, but we found the cells in Wembley cold. All cells had some natural light. Smoking was not allowed and smokers were not offered nicotine replacement therapy.

4.13 Cells were checked daily, but it was not clear that they were thoroughly checked between uses and, while PC gaolers and DDOs removed any debris after use, mattresses and pillows were not routinely wiped down. Contract cleaners attended every morning and throughout the day if required to clean up spillages. We saw cleaners responding quickly to clean a cell at Kilburn

following a dirty protest. There were no obvious ligature points in cells at Wembley, but several at Kilburn. The BOCU took urgent remedial action when advised of this, closing the custody suite and liaising with the estates department to resolve the problem. (See main recommendations.)

4.14 Fire alarms were tested regularly and there were frequent evacuation drills and desk top exercises. Handcuffs for use in an evacuation were readily accessible at Wembley. At Kilburn, where the most recent fire practice had been in March 2010, evacuation plans included detainees wearing tabards and handcuffs and, where possible, each having a nominated officer 'partner'.

4.15 All cell bells were in working order and those at Kilburn had been tested by an outside contractor in April 2010. Staff said they explained the use of cell bells to detainees, but this did not happen with one detainee we observed at Wembley. Cell bells were responded to reasonably quickly, but one detainee said his bell had been cancelled during the night without staff speaking to him and there was no record of this in the custody log. Detainees whose cell bells were isolated due to persistent use were checked regularly and the isolation was for a limited time.

Personal comfort and hygiene

4.16 All cells contained a mattress and a pillow, but blankets were not routinely provided and we saw one detainee held overnight who was not given one. At Kilburn, a detainee who had conducted a dirty protest and used a blanket to block his toilet was denied another mattress, pillow or blanket when moved to a clean cell and his custody log contained no record that he had been offered a wash or shower. Hygiene items, such as razors, shower gel, toothbrushes and toothpaste, were available on request. Female detainees were not routinely offered a hygiene pack.

4.17 Detainees could use the toilet in private, but toilet paper had to be requested and there were no in-cell hand washing facilities. The two showers at Wembley could be used in private, but were small and ran cold. Those at Kilburn were larger and had warm water. Detainees were rarely offered a shower and only paper towels were provided.

4.18 Paper suits, jogging bottoms, T-shirts and plimsolls were available, but in limited supply and in a limited range of sizes. No replacement underwear was provided. Staff said detainees whose clothes had been seized were usually given a paper suit unless they were being released or attending court. We saw one detainee at Wembley wearing a paper suit in the busy booking in area. Family and friends were allowed to bring in clothing.

Catering

4.19 The canteens offered a good range of meals for breakfast, lunch and dinner, and additional meals, including vegetarian and halal options, could be provided. Meal times appeared to depend on how busy the suite was. Hot drinks were given on request. Staff had not been trained in food handling and food temperatures were not taken before serving.

Activities

4.20 Both suites had a small exercise yard, but detainees were rarely offered the opportunity to use them. A custody log at Wembley indicated that one detainee held for almost 48 hours had

been offered a little time outside. There was some limited reading material, but this was not routinely offered and there was nothing for detainees with learning or sight difficulties. One detainee at Kilburn said staff had refused their request for a magazine during the night. There were no visits rooms and visits were authorised only in exceptional circumstances.

Recommendations

4.21 Booking in areas should allow enough privacy to enable effective communication between staff and detainees and between detainees and those they telephone.

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

4.23 There should be clear protocols for the use of Tasers in custody suites, including a definition of the circumstances in which use can be considered.

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

4.25 Detainees held overnight and those who require it should be offered a shower and clean towels.

4.26 Replacement clothing should be available in an appropriate range of sizes and a change of underwear provided for all detainees when appropriate.

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

Housekeeping points

4.28 All female detainees should be offered a hygiene pack on arrival.

4.29 Food temperatures should be checked and recorded before serving.

4.30 Reading material should be available in easy-read formats for detainees with learning disabilities.

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 detention was appropriate before authorising it and at Wembley had occasionally deemed it inappropriate. The custody sergeant at Kilburn had never refused detention, but said he always checked the full facts of the arrest. In Kilburn, police custody was not used as a place of safety for children under section 46 of the Children Act 1989, but had occasionally been used as such at Wembley. The custody sergeant said a young person from overseas had been brought in the previous week by social workers, but had later been certified as an adult and released.

5.2 Custody sergeants followed up with investigating officers driving the enquiry to ensure that detention lasted no longer than appropriate. At Wembley, bail was considered if the case was not progressed as necessary. Most reviews by inspectors took place in person with detainees.

5.3 Detainees were routinely advised on arrival that they were entitled to have someone concerned for their welfare informed of their whereabouts. Custody staff placed these calls before passing the telephone to the detainee. The reason for any delay in making the call was authorised by the custody sergeant.

5.4 Staff at both suites said about one immigration detainee was received each day. There were proactive links with the UKBA, but custody staff described some delays in dealing with immigration detainees and said they could be held for three or four days. There was reasonable access to telephone interpreters and two-way handsets were available at Wembley. Staff at Wembley had found it difficult to get a Ghanaian interpreter and eventually used one to communicate information to the detainee, including their rights and entitlements, by telephone using broken English. All detainees are offered a copy of their rights and entitlements and these were available in a range of languages, although not Ghanaian. Custody staff said face-to-face interpreters responded reasonably promptly when requested. Front line phrase books were available in both suites in eight languages. Nothing was available in easy to read format.

5.5 The NSPIS custody system prompted staff to ask detainees about any dependents for whom they were responsible and we saw staff at Kilburn going to some trouble in the early hours of the morning to reassure a detainee about the wellbeing of a child at home. Telephone calls were facilitated and more than one was often authorised when necessary.

5.6 Pre-release risk assessments were completed when deemed necessary and action taken included lifts home and recommending detainees speak to drugs workers. Staff worked hard to deal with domestic issues before detainees were released and women vulnerable to domestic violence received a particularly good service. However, one juvenile released at 5am was not offered a lift home. A leaflet detailing support organisations and agencies was available to those who might need it.

Rights relating to PACE

5.7 Up-to-date copies of PACE were regularly offered to detainees. There was no evidence that detainees were interviewed while under the influence of alcohol or drugs, or that they were denied adequate breaks during the interview process. A doctor was called if there was any doubt about a detainee's fitness for interview, although the custody sergeant at Wembley said the assessment sometimes took place by telephone. A wait of two hours or more to see a doctor was not unusual. An ambulance was called in an emergency.

5.8 There was a duty solicitor scheme and posters offering free legal advice were displayed in a range of languages. Custody records indicated that all detainees were routinely offered legal advice. Detainees were more likely to be able to consult their solicitors by telephone in private at Wembley than Kilburn due to the location of the telephone (see section on respect). However, neither suite offered complete privacy when making calls. Immigration advice at both suites was mainly provided by telephone. Legal representatives could get copies of the two front sheets of the custody record and many routinely asked for these on arrival at the custody suite.

5.9 Family and friends were usually considered as possible appropriate adults in the first instance. If this was not possible or feasible, Brent Social Services and the emergency duty team provided appropriate adults for juveniles and detainees with mental health and learning difficulties. Social services insisted that a legal representative be present during interview. The social services appropriate adult service was available from 9am to 5pm and the emergency duty team service from 5pm usually until 10pm, although this was more limited at weekends. Police adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant those aged 17 were not routinely provided with an appropriate adult unless otherwise deemed vulnerable[5]. (See main recommendations.)

5.10 The management of DNA and forensic samples was good, with the only minor issue being some confusion among staff about submitting samples to the national DNA database. A very small number had not been submitted and were listed as 'missing' on the police national computer.

5.11 Detainees who were charged were promptly put before the courts. Detainees had to be at the local Brent Magistrates Court by 2pm during the week and 10am on Saturdays. There were no video link facilities.

Rights relating to treatment

5.12 Detainees were not routinely told how to make a complaint and this information was not included in the rights and entitlements leaflets.[6] Some staff said they would deal with some issues. Custody sergeants said complaints could not be taken while a detainee was in custody. They advised anyone wanting to make a complaint to see the inspector on release and made a record of the complaint in the custody log. This was not the expectation of senior managers, who were clear that complaints should be dealt with as soon as practicable and internally by the duty inspector where possible. IPCC complaint forms were handed to detainees at Kilburn

[5] Although this met the current requirements of PACE, in all other parts of the criminal justice system, and international treaty obligations, 17 year olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

[6] IPCC statutory guidance to the police service and police authorities on the handling of complaints, 2010.

on release. There was no comprehensive central recording of complaints in custody and no separate system for reporting and dealing with racist incidents.

Recommendations

5.13 Detainees who have difficulty communicating in English should be provided for and the rights and entitlements information made available in easy-read format.

5.14 Detainees, including immigration detainees, should be able to consult with their legal representative in private.

5.15 The borough operational command unit should ensure that all staff understand DNA policies and that samples are submitted promptly to the national DNA database.

5.16 Detainees should be told how to make a complaint and they should be facilitated to do so before they leave custody.

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.

Clinical governance

6.1 Custody staff were aware of the health needs of detainees and treated them respectfully and compassionately. FMEs and drug workers appeared committed to providing a high level of care and support. Most FMEs were male. Efforts were made to allow a female detainee to see a female FME if requested, but this was not always possible as only one FME was on call at any one time. Chaperones were routinely offered to female detainees and juveniles. Telephone and face-to-face interpreters were available and there was a dedicated telephone in the Kilburn FME room.

6.2 Independent FMEs were contracted by the MPA Forensic Health Services (FHS), who also used agency doctors when necessary. One FME, a part-time local GP, said FMEs came from a wide range of clinical backgrounds, including hospital consultants and GPs. There was no lead FME, but a medical director had recently been appointed by the MPA to oversee the management of FMEs. All FMEs were responsible for managing their ongoing professional development, professional registration and appraisal system. For most, this was done through their other work. Complaints were now managed by the medical director and police staff said the procedure had improved as a result.

6.3 Drug workers were managed by their parent company and were fully supported in maintaining their professional development. They had access to both monthly supervision and an impressive level of internal and external professional training.

6.4 The FME rooms at both suites were located centrally and provided a good degree of privacy. Access was limited to custody staff and FMEs. The door was clearly signed and kept locked when the room was not in use. The key was held securely. The examination couches were not screened and detainees were not given a blanket when undergoing clinical examination. At Wembley, clinical and general waste was segregated into separate bins and removed regularly.

6.5 The overall management of medicines was good, apart from some overstocking and incorrect auditing. Pharmacy reference books were available. Lockable medicines cabinets contained a comprehensive and appropriate stock of medicines. Medicines were ordered through FMS and delivered by courier to the nominated custody sergeant. FMEs also carried their own stock for use in urgent situations, particularly out of hours. Historically FMEs had their own keys to the medicines cabinets, but some of these had been 'mislaid' and the practice was being reviewed to reduce risk. (See main recommendations.)

6.6 Medication brought in by detainees on arrival was removed and stored with the detainee's property. However, there were no arrangements to ensure it was securely locked away, which was in breach of current legislation and national guidance. Detainees could use their own medication only once it had been seen and approved by an FME. Where necessary, medicines were dispensed into Henley bags and labelled by the FME with clear instructions for

administration by custody staff. Any medicines administered by custody staff were recorded on NSPIS.

6.7 Controlled drugs were regulated and a register of their administration was held. At Wembley, diazepam (5mg) tablets and dihydrocodeine (30) tablets were recorded in the controlled drugs register. There were significant discrepancies in the stock levels of diazepam and dihydrocodeine tablets at Wembley. There were also excessive stocks of Ibuprofen tablets (1000+). Stock levels at Kilburn were correct, but rectal diazepam was not recorded properly. The responsible custody officer was aware of this and dealing with it.

6.8 Emergency and resuscitation equipment was limited and did not contain oxygen or resuscitation drugs, but did include a defibrillator. Staff had been trained in its use and undertook annual updates. The equipment was checked every day at shift handover.

Patient care

6.9 Detainees could ask to see a health care professional at any point and would be asked the reason why to determine the level of urgency. The FMEs covered two adjacent boroughs and we were told another station had been added to the workload. This was having a negative effect on response times due to heavy traffic in the area. Custody staff and FMEs were concerned about protracted response times, but there was no evidence that these were monitored by the police, and custody staff did not know what the contracted expected response time was. Records indicated a maximum response time of three hours, although anecdotal evidence suggested this was often longer. If a detainee began to display obvious signs of physical or mental health need, the custody officer called the FME and noted it on the custody record. Anyone in great physical discomfort was taken to the nearest accident and emergency department or an ambulance would be called. (See main recommendations.)

6.10 FMEs provided symptomatic relief for substance users. Methadone or heroin users could wait up to six hours for relief unless they displayed signs of gross withdrawal. Methadone was not routinely prescribed, although one FME said he would do so if this had been verified by the detainee's GP or drug worker. The six-hour period would also be imposed to ensure safety.

6.11 The FME made an entry in the custody record following any contact with a detainee. This provided sufficient information to allow custody staff to manage that detainee as safely as possible. FMEs also kept their own more comprehensive clinical records. Those we spoke to recorded and stored clinical records in different ways, but arrangements were not monitored and no checks were made to ensure records were stored securely or that processes were in place for safe archiving. Recording of health care interventions was therefore inconsistent.

6.12 Drugs workers completed a comprehensive assessment that was signed by the detainee. A copy of the confidentiality form was given to the client, who could request to see their file at any time. Only brief information was shared with custody staff, who entered it in the custody record.

6.13 Detainee written consent to intervention or treatment was not recorded. FMEs we spoke to said they ensured verbal consent for some procedures, but this practice was not observed.

Substance use

6.14 The Westminster Drugs Project (WDP) provided a comprehensive client-centred substance misuse service, including alcohol, to adults in all custody suites. Juveniles were seen and

assessed in the presence of an appropriate adult and referred to adolescent services. WDP had developed information-sharing protocols with the police, courts and local prisons, ensuring a good level of continuity of substance users. A dedicated drug worker had made excellent links with local remand prisons and went there every week following up clients and attending continuity of care meetings. The meetings included representatives from prison counselling, assessment, referral, advice and throughcare teams, prison health care and other substance misuse agencies. Stable clients were referred to their own GPs and local mental health services. WDP also provided a rapid prescribing scheme and other services where necessary, including ethnic minority counselling services and alcohol services. Out-of-borough clients were assessed and referred to their home substance misuse team.

6.15 Injecting drug users were not given clean needles or syringes, but were told where to get them. There were limited alcohol services and alcohol users were signposted to supportive community services and given written information and advice. Drug workers were available between 7am and 11pm on weekdays. The team of six workers had completed over 60 assessments between January and April 2010. The most common substances used were cannabis and alcohol. The team carried out a sweep of all cells twice a day to ensure anyone with drug or alcohol problems was offered advice and support. Detainees requiring advice and support out of hours were given an appointment for noon the following day at the WDP base. The police issued a standard letter to the detainee on release giving appointment information and contact details. They also faxed the detainee's details to WDP to confirm.

Mental health

6.16 Arrangements for the care and treatment of detainees with mental health problems were provided by a specialist provider, the Central & North West London NHS Foundation Trust. The mental health crisis team was based at Park Royal Centre for Mental Health.

6.17 There were very good links between the various crisis teams operating in the trust. All referrals for initial mental health assessment were made through the FME, some of whom were Mental Health Act section 12 approved. An onward referral to the mental health crisis team was then made if appropriate. Trust staff reported good working relationships with FMEs and said referrals were always appropriate. There was some concern about occasional significant delays in the crisis team attending the custody suite. The approved mental health practitioner coordinated the mental health assessment process, including the provision of an appropriate adult if required, and this was carried out in good time.

6.18 General mental health assessments were carried out according to an agreed protocol. Ongoing packages of treatment and care were put in place for Brent borough residents, while others were referred to their local borough team for general assessment. Custody staff said this delayed the assessment process significantly. FMEs said levels of mental health awareness varied among custody staff. Some additional training was under discussion, but had not yet been implemented.

6.19 Monthly meetings about dual diagnosis were held with Compass, the borough's alcohol service provider.

6.20 An out-of-hours emergency team conducted Mental Health Act assessments. Routine assessments were not carried out after 11pm, but FMEs could get support from local accident and emergency departments through the Trust crisis line. There were regular joint meetings between the mental health team and the police regarding section 136 and accident and

emergency liaison. A designated police link officer attended the meeting. A small court diversion team made referrals to the crisis team as necessary.

6.21 Arrangements for the care and treatment of detainees with mental health problems were good. A designated police officer had been involved in shared mental health protocol development.

6.22 Relationships between the police and mental health staff were very good and detention of people under section 136 was rare. There were agreed protocols for section 136 suites, which appeared to work well. Police remained on site for one hour or by negotiation, until assessment was complete. Custody staff and the FME said patients were only detained in the custody suite while under the influence of drugs or alcohol, pending regaining fitness for assessment. The mental health authority provided a section 136 suite at Park Royal Centre for detainees held at Kilburn and Wembley.

Recommendations

6.23 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.

6.24 All custody staff and health care professionals should be aware of and adhere to the FMS *Guidelines for the Security, Management and Disposal of Drugs and Medicines in Custody*.

6.25 Discrepancies in the register of controlled drugs should be reported to the chain of command and the PCT accountable officer at the earliest opportunity.

6.26 FHS should ensure custody staff have the appropriate equipment to manage immediate medical emergencies.

6.27 There should be ongoing audits of forensic medical examiner response times and custodial staff should be given clear instructions on what information they should provide to ensure effective monitoring and management of the contract for this service.

6.28 Health care professionals should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance on the use and confidentiality of personal health information and there should be clear protocols on how long clinical records should be kept.

Housekeeping points

6.29 Mobile screens and blankets should be provided in forensic medical examiner rooms.

6.30 The number of personnel holding keys to the medicine cabinets should be changed so that only one set of keys is in use at any one time.

6.31 Detainees should have invasive procedures fully explained to them and written consent for any such procedures should be obtained and retained.

6.32 Regular mental health awareness training should be provided to all custody staff.

Good practice

6.33 *A designated police officer had been involved in shared mental health protocol development.*

7. Summary of recommendations

Main recommendations — To the Metropolitan Police Service

7.1 Staff and other employees who operate in the custody environment should not be deployed in custody suites until they have received custody-specific training, including on how to use the NSPIS custody system. (2.23, see paragraph 2.8)

7.2 The Metropolitan Police Service should collate the use of force in accordance with Association of Chief Police Officers policy and National Police Improvement Agency guidance. (2.24, see paragraph 2.9)

7.3 All cells should be suitable for detaining individuals and clear of graffiti, odour and ligature points. (2.25, see paragraph 2.13)

7.4 Appropriate adults should be available 24 hours a day to support juveniles aged 17 and under and vulnerable adults in custody. (2.26, see paragraph 2.16)

7.5 Staff should adhere to the MPS guidelines for the management of drugs and medicines in custody. Missing medicines, particularly controlled drugs, should immediately be notified to the primary care trust accountable officer. (2.27, see paragraph 2.19)

Recommendation — To the Metropolitan Police Authority

Strategy

7.6 The Metropolitan Police Authority should allocate one authority member as lead for custody. (3.15, see paragraph 3.1)

Recommendations — To the Metropolitan Police Service

Strategy

7.7 Custody records should be routinely dip-sampled and compared with contemporaneous CCTV footage. The number checked each time should ensure a meaningful representative sample of detainees held in custody and include examples of all custody officers working in this area. (3.16, see paragraph 3.11)

7.8 The Metropolitan Police Service should urgently address the force-wide and borough shortcomings in terms of extracting management information from NSPIS to focus critical thinking, including the structural processes and IT deficiencies that inhibit this. (3.17, see paragraph 3.12)

Treatment and conditions

7.9 Booking in areas should allow enough privacy to enable effective communication between staff and detainees and between detainees and those they telephone. (4.21, see paragraph 4.3)

7.10 There should be clear local policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.22, see paragraphs 4.4 and 4.5)

7.11 There should be clear protocols for the use of Tasers in custody suites, including a definition of the circumstances in which use can be considered. (4.23, see paragraph 4.11)

7.12 Subject to individual needs assessment, nicotine replacement should be available to detainees. (4.24, see paragraph 4.12)

7.13 Detainees held overnight and those who require it should be offered a shower and clean towels. (4.25, see paragraph 4.17)

7.14 Replacement clothing should be available in an appropriate range of sizes and a change of underwear provided for all detainees when appropriate. (4.26, see paragraph 4.18)

7.15 Wherever possible, detainees held for longer periods should be offered outdoor exercise and visits. (4.27, see paragraph 4.20)

Individual rights

7.16 Detainees who have difficulty communicating in English should be provided for and the rights and entitlements information made available in easy-read format. (5.13, see paragraph 5.4)

7.17 Detainees, including immigration detainees, should be able to consult with their legal representative in private. (5.14, see paragraph 5.8)

7.18 The borough operational command unit should ensure that all staff understand DNA policies and that samples are submitted promptly to the national DNA database. (5.15, se paragraph 5.10)

7.19 Detainees should be told how to make a complaint and they should be facilitated to do so before they leave custody. (5.16, see paragraph 5.12)

Health care

7.20 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. (6.23, see paragraph 6.2)

7.21 All custody staff and health care professionals should be aware of and adhere to the FMS *Guidelines for the Security, Management and Disposal of Drugs and Medicines in Custody*. (6.24, see paragraph 6.7)

7.22 Discrepancies in the register of controlled drugs should be reported to the chain of command and the PCT accountable officer at the earliest opportunity. (6.25, see paragraph 6.7)

7.23 FHS should ensure custody staff have the appropriate equipment to manage immediate medical emergencies. (6.26, see paragraph 6.8)

7.24 There should be ongoing audits of forensic medical examiner response times and custodial staff should be given clear instructions on what information they should provide to ensure effective monitoring and management of the contract for this service. (6.27, see paragraph 6.9)

7.25 Health care professionals should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance and there should be clear protocols on how long clinical records should be kept. (6.28, see paragraph 6.11)

Housekeeping points

Treatment and conditions

7.26 All female detainees should be offered a hygiene pack on arrival. (4.28, see paragraph 4.16)

7.27 Food temperatures should be checked and recorded before serving. (4.29, see paragraph 4.19)

7.28 Reading material should be available in easy-read formats for detainees with learning disabilities. (4.30, see paragraph 4.20)

Health care

7.29 Mobile screens and blankets should be provided in forensic medical examiner rooms. (6.29, see paragraph 6.4)

7.30 The number of personnel holding keys to the medicine cabinets should be changed so that only one set of keys is in use at any one time. (6.30, see paragraph 6.5)

7.31 Detainees should have invasive procedures fully explained to them and written consent for any such procedures should be obtained and retained. (6.31, see paragraph 6.13)

7.32 Regular mental health awareness training should be provided to all custody staff. (6.32, see paragraph 6.18)

Good practice

Health care

7.33 *A designated police officer had been involved in shared mental health protocol development.* (6.33, see paragraph 6.21)

Appendix I: Inspection team

Sara Snell	HMIP team leader
Anita Saigal	HMIP inspector
Paddy Craig	HMIC inspector
Angela Johnson	HMIP inspector
Kellie Reeve	HMIP inspector
Bridget McEvilly	HMIP health care inspector
Jan Fooks-Bale	CQC inspector
Adam Altoft	HMIP researcher
Sherrelle Parke	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Brent police custody, a sample of the custody records of detainees held at both Kilburn and Wembley police custody suites were analysed between 2 and 12 April 2010. Custody records were held electronically on NSPIS. A total sample of 30 records were analysed from across the borough of Brent:

Custody suite	Number of records analysed
Kilburn	15
Wembley	15
Total	30

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 (17%) of the detainees were female and 25 (83%) were male.
- Three (10%) people under the age of 17 were included in the sample.
- There were 11 (37%) detainees in our sample from a white background and 19 (63%) detainees from a black, Asian or mixed ethnic minority background.
- Four (13%) detainees had been held for more than 24 hours and one detainee had been held for exactly 24 hours. Thirteen (43%) detainees had been in custody overnight, including those who had arrived during the night and were not released until the morning (between midnight and 6am). Ten (33%) detainees had been held for less than six hours.
- There were six (20%) foreign nationals in the sample and all were provided with their foreign national rights.

Risk assessments

Initial risk assessment statements were largely clear and contained helpful information.

- Ten detainees (33%) were brought into custody intoxicated and nine were seen by a medical professional according to the notes in their detainee logs. The other detainee had visited hospital before arriving in custody. However, staff later called for a medical professional to attend custody to see the detainee, but there is no record of them arriving. None of the detainees who were intoxicated saw a drug or alcohol worker, although one detainee who was not intoxicated did see one.
- Two (7%) detainees had current or previous self-harm or suicide issues. Of the two, one detainee was monitored in a CCTV cell.
- Five (17%) detainees in our sample had reported mental health problems. Of the five, it was noted that an appropriate adult was required for one detainee. The appropriate adult was present for the detainee's interview, but the record notes that the detainee was charged without the presence of an appropriate adult as they were no longer available. The detention log also states that the detainee was on medication and lived in supported housing, although this was not recorded on the risk assessment. However, custody staff did try to contact staff at the supported accommodation to clarify the nature of the medication prescribed to the detainee.

- Five (17%) detainees in our sample reported being on medication on arrival in custody. Three of these detainees were seen by a health care professional during their time in custody.
- Four (13%) detainees in our sample arrived in custody with an injury and two were seen by a health care professional. One detainee had arrived from hospital and staff had later called for an FME, but the record does not show whether they arrived. The other detainee's log states the presence of injuries, but these were not recorded on the risk assessment. During the detainee's stay, a doctor was requested, but later called back and directed staff to administer the detainee with paracetamol.
- In four (13%) risk assessments, it was noted to be a detainee's first time in custody.

Removal of clothing

One (3%) detainee in the sample had their clothing removed. They were immediately provided with an evidence suit and plimsolls as replacement clothing and footwear.

Young people

There were three (10%) young people in our sample aged under 17.

- All three young people had an appropriate adult with them during their stay, although for one of the detainees it was not clear what time the appropriate adult arrived. All three appropriate adults were a parent of the young person.
- Two of the young people were aged 13 or under and it was their first time in custody. Although staff had acknowledged that both required an appropriate adult, neither was acknowledged as vulnerable by staff completing their risk assessments.
- One young person spent nearly 13 hours in custody. He was offered five meals during this time.

Women

- Of the five female detainees in the sample:
    - One female detainee accepted the offer to speak with a female member of staff in private. For another detainee, there was no indication that she was offered the chance to speak with a female member of staff.

Interpreters

- Two (6%) detainees in the sample required the use of an interpreter.
    - One detainee had an interpreter present during interview. They were initially booked in using a professional telephone interpreting service, but their rights and entitlements were later reiterated on the arrival of their interpreter.
    - For another detainee, they were provided with their rights before the arrival of the interpreter. Though the log notes the arrival of an interpreter, it was not clear whether they were in attendance for the interview of the detainee.

Inspector reviews

Inspector reviews were held in line with requirements, usually at the required times. However, in a number of cases, inspectors were conducting reviews while the detainee was asleep.

Services

- All detainees were offered the opportunity of having someone informed of their arrest, notwithstanding operational reasons. In addition, three (10%) detainees had made a telephone call during their time in custody. Two (6%) detainees requested to make a call, but these were not granted, usually because the custody suite was busy at the time. For 25 (83%) detainees, there was no record of them being offered a telephone call during their time in custody, even though three were in custody for 24 hours or more and there were no operational reasons detailed that showed they should not be offered a telephone call.
- Detainees were routinely offered legal advice, but only 14 (47%) detainees accepted.
- Twelve (40%) detainees were seen by the FME.
    - The longest wait was approximately six hours 33 minutes.
    - The average wait for an FME was approximately one hour 39 minutes.
    - Three detainees had notes on their logs detailing that the services of an FME were required and that an FME had been contacted, but none of these detainees got to see one before they were released.
- Twenty-two (73%) detainees in our sample were offered at least one meal while in custody. Eight (27%) detainees were not offered a meal while in custody. All but two of these detainees were in custody for less than six hours.
- No detainees in the custody sample had been offered outside exercise.
- No detainees had a shower while in custody. One detainee was offered, but declined, a 'wash'.
- Two detainees had been provided with reading materials.
- There was no evidence of cell sharing.

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 Brent, 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 11 May 2010. The survey for Brent was conducted alongside a survey for the police boroughs of Kensington and Chelsea, and Harrow. A list of potential respondents who may have passed through these three police boroughs was created, listing all those who had arrived from Harrow, Brent, Hendon, Uxbridge or West London Magistrates courts within the past month.

Selecting the sample

On the day, the questionnaire was offered to 79 respondents who had passed through Brent, Kensington and Chelsea, and Harrow police boroughs. There were four refusals, five questionnaires returned blank and six non-returns. All those sampled had been in custody within the last three months[7]. Twenty-six questionnaires were returned completed from prisoners who had been through the borough of Brent.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, two respondents who had been through the borough of Brent 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.

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

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses 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 28 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 have been weighted for comparison purposes.

Survey results

Section 1: About you

Q2 What police station were you last held at?
Wembley (19) and Kilburn (7) Police Station

Q3 What type of detainee were you?

Police detainee	20 (95%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	0 (0%)
Immigration detainee	0 (0%)
I don't know	1 (5%)

Q4 How old are you?

16 years or younger	0 (0%)	*40-49 years*	5 (19%)
17-21 years	1 (4%)	*50-59 years*	1 (4%)
22-29 years	7 (27%)	*60 years or older*	1 (4%)
30-39 years	11 (42%)		

Q5 Are you:

Male	26 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 What is your ethnic origin?

White - British	7 (29%)
White - Irish	2 (8%)
White - other	3 (13%)
Black or black British - Caribbean	5 (21%)
Black or black British - African	1 (4%)
Black or black British - other	1 (4%)
Asian or Asian British - Indian	2 (8%)
Asian or Asian British - Pakistani	2 (8%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	1 (4%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	6 (26%)
No	17 (74%)

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

None	2 (8%)
Church of England	6 (24%)
Catholic	7 (28%)
Protestant	0 (0%)
Other Christian denomination	2 (8%)

Buddhist 0 (0%)
Hindu 1 (4%)
Jewish 0 (0%)
Muslim 7 (28%)
Sikh 0 (0%)

Q9 How would you describe your sexual orientation?

Straight/heterosexual 24 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q10 Do you consider yourself to have a disability?

Yes 4 (17%)
No 17 (71%)
Don't know 3 (13%)

Q11 Have you ever been held in police custody before?

Yes 22 (92%)
No 2 (8%)

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

1 hour or less 0 (0%)
More than 1 hour, but less than 6 hours 2 (8%)
More than 6 hours, but less than 12 hours 0 (0%)
More than 12 hours, but less than 24 hours 6 (23%)
More than 24 hours, but less than 48 hours (2 days) 6 (23%)
More than 48 hours (2 days), but less than 72 hours (3 days) 8 (31%)
72 hours (3 days) or more 4 (15%)

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

Yes 18 (72%)
No 2 (8%)
Don't know/can't remember 5 (20%)

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

Yes 9 (36%)
No 14 (56%)
I don't know what this is/I don't remember 2 (8%)

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

My clothes were not taken 16 (73%)
I was offered a tracksuit to wear 5 (23%)
I was offered an evidence suit to wear 0 (0%)
I was offered a blanket 1 (5%)

Q16 Could you use a toilet when you needed to?

Yes 23 (88%)
No 3 (12%)
Don't know 0 (0%)

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

	Yes	*No*
Toilet paper	15 (58%)	11 (42%)
Sanitary protection	*7 (37%)*	*12 (63%)*

Q18 Did you share a cell at the police station?

Yes 0 (0%)
No 25 (100%)

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	10 (38%)	9 (35%)	7 (27%)
Ventilation/air quality	4 (18%)	5 (23%)	13 (59%)
Temperature	6 (26%)	6 (26%)	11 (48%)
Lighting	11 (50%)	4 (18%)	7 (32%)

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

Yes 12 (52%)
No 11 (48%)

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

Yes 7 (28%)
No 18 (72%)

Q22 Were you held overnight?

Yes 25 (96%)
No 1 (4%)

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

Not held overnight 1 (3%)
Pillow 7 (23%)
Blanket 15 (50%)
Nothing 7 (23%)

Q24 Were you offered a shower at the police station?

Yes 3 (12%)
No 22 (88%)

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

Yes 1 (4%)
No 23 (96%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	18 (75%)	6 (25%)
Drink?	18 (78%)	5 (22%)

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

I did not have any food or drink 7 (27%)
Yes 10 (38%)
No 9 (35%)

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

I do not smoke	4 (15%)
I was allowed to smoke	3 (11%)
I was not offered anything to cope with not smoking	17 (63%)
I was offered nicotine gum	1 (4%)
I was offered nicotine patches	1 (4%)
I was offered nicotine lozenges	1 (4%)

Q29 Were you offered anything to read?

Yes	5 (20%)
No	20 (80%)

Q30 Was someone informed of your arrest?

Yes	12 (48%)
No	12 (48%)
I don't know	0 (0%)
I didn't want to inform anyone	1 (4%)

Q31 Were you offered a free telephone call?

Yes	15 (60%)
No	10 (40%)

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

My telephone call was not denied	15 (60%)
Yes	1 (4%)
No	9 (36%)

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 (17%)	10 (83%)
Contacting your partner, relative or friend	10 (56%)	8 (44%)
Contacting your employer	5 (36%)	9 (64%)
Where you were going once released	8 (50%)	8 (50%)

Q34 Were you interviewed by police officials about your case?

Yes	21 (84%)	
No	4 (16%)	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	18 (86%)	0 (0%)	3 (14%)
Appropriate adult	2 (18%)	4 (36%)	5 (45%)
Interpreter	1 (8%)	3 (23%)	9 (69%)

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

I did not requested a solicitor	5 (22%)
2 hours or less	1 (4%)
Over 2 hours but less than 4 hours	3 (13%)
4 hours or more	14 (61%)

Q37 Were you officially charged?

Yes	20 (83%)
No	3 (13%)
Don't know	1 (4%)

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

I have not been charged yet	3 (13%)
1 hour or less	1 (4%)
More than 1 hour, but less than 6 hours	2 (8%)
More than 6 hours, but less than 12 hours	3 (13%)
12 hours or more	15 (63%)

Section 3: Safety

Q40 Did you feel safe there?

Yes	11 (50%)
No	11 (50%)

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

Yes	7 (32%)
No	15 (68%)

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

I have not been victimised	15 (54%)	*Because of your crime*	4 (14%)
Insulting remarks (about you, your family or friends)	2 (7%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	2 (7%)	*Because you have a disability*	1 (4%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	1 (4%)
Your race or ethnic origin	2 (7%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	1 (4%)		

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

Yes	7 (35%)
No	13 (65%)

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

Yes	5 (23%)
No	17 (77%)

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

Yes	1 (5%)
No	19 (95%)

Section 4: Health care

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

Yes	7 (32%)
No	15 (68%)

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

Not taking medication	15 (79%)
Yes	1 (5%)
No	3 (16%)

Q49 Did someone explain your entitlements to see a health care professional if you needed to?

Yes	8 (36%)
No	11 (50%)
Don't know	3 (14%)

Q50 Were you seen by the following health care professionals during your time there?

	Yes	*No*
Doctor	13 (62%)	8 (38%)
Nurse	1 (8%)	12 (92%)
Paramedic	2 (15%)	11 (85%)
Psychiatrist	1 (8%)	12 (92%)

Q51 Were you able to see a health care professional of your own gender?

Yes 10 (48%)
No 9 (43%)
Don't know 2 (10%)

Q52 Did you have any drug or alcohol problems?

Yes 10 (45%)
No 12 (55%)

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 12 (57%)
Yes 4 (19%)
No 5 (24%)

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

I didn't have any drug/alcohol problems 12 (57%)
Yes 2 (10%)
No 7 (33%)

Q55 Please rate the quality of your health care while in police custody:

	I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
Quality of health care	7 (32%)	0 (0%)	3 (14%)	4 (18%)	3 (14%)	5 (23%)

Q56 Did you have any specific <u>physical</u> health care needs?

No 12 (60%)
Yes 8 (40%)

Q57 Did you have any specific <u>mental</u> health care needs?

No 16 (84%)
Yes 3 (16%)

Prisoner survey responses for Brent police 2010

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

Key to tables

	Any percent highlighted in green is significantly better	Brent police	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		26	905
SECTION 1: General information			
2	Are you a police detainee?	**95%**	**88%**
3	Are you under 21 years of age?	**4%**	**9%**
4	Are you transgender/transsexual?	**0%**	**1%**
5	Are you from a minority ethnic group (including all those who did not tick White British, White Irish or White other categories)?	**50%**	**35%**
6	Are you a foreign national?	**27%**	**16%**
7	Are you Muslim?	**27%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**17%**	**19%**
10	Have you been in police custody before?	**91%**	**90%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24 hours?	**70%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**73%**	**73%**
13	Were you told about PACE?	**35%**	**52%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**83%**	**44%**
15	Could you use a toilet when you needed to?	**88%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**58%**	**50%**
17	Did you share a cell at the station?	**0%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**38%**	**29%**
18b	Ventilation/air quality?	**19%**	**20%**
18c	Temperature?	**27%**	**13%**
18d	Lighting?	**50%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**52%**	**56%**
20	Did staff explain the correct use of the cell bell?	**27%**	**21%**
21	Were you held overnight?	**96%**	**91%**
22	If you were held overnight, were you given **no** clean items of bedding?	**27%**	**31%**
23	Were you offered a shower?	**13%**	**9%**
24	Were you offered a period of outside exercise?	**4%**	**6%**
25a	Were you offered anything to eat?	**75%**	**80%**
25b	Were you offered anything to drink?	**78%**	**81%**
26	Was the food/drink you received suitable for your dietary requirements?	**53%**	**43%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**72%**	**78%**
28	Were you offered anything to read?	**21%**	**13%**
29	Was someone informed of your arrest?	**48%**	**43%**
30	Were you offered a free telephone call?	**60%**	**52%**

Key to tables

		Brent police	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
31	If you were denied a free call, was a reason given?	11%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	17%	16%
32b	Contacting your partner, relative or friend?	56%	52%
32c	Contacting your employer?	37%	21%
32d	Where you were going once released?	50%	31%
34	If you were interviewed were the following people present:		
34a	Solicitor	85%	73%
34b	Appropriate adult	19%	8%
34c	Interpreter	8%	7%
35	Did you wait over four hours for your solicitor?	77%	64%
37	Were you held 12 hours or more in custody after being charged?	71%	62%
SECTION 3: Safety			
39	Did you feel unsafe?	50%	41%
40	Has another detainee or a member of staff victimised you?	31%	42%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	10%	22%
41b	Physical abuse (being hit, kicked or assaulted)	10%	14%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	10%	6%
41e	Drugs	5%	15%
41f	Because of your crime	19%	17%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	5%	3%
41i	Because of your religion/religious beliefs	5%	3%
41j	Because you are from a different part of the country than others	0%	5%
42	Were you handcuffed or restrained while in the police custody suite?	34%	48%
43	Were you injured while in police custody, in a way that you feel is not your fault?	23%	36%
44	Were you told how to make a complaint about your treatment?	5%	13%
SECTION 4: Health care			
46	Were you on any medication?	31%	44%
47	For those who were on medication: were you able to continue taking your medication?	25%	39%
48	Did someone explain your entitlement to see a health care professional if you needed to?	36%	35%
49	Were you seen by the following health care professionals during your time in police custody?		
49a	Doctor	63%	50%
49b	Nurse	8%	14%
49c	Paramedic	16%	4%
49d	Psychiatrist	8%	4%
50	Were you able to see a health care professional of your own gender?	48%	28%
51	Did you have any drug or alcohol problems?	45%	54%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	44%	40%
53	Were you offered relief medication for your immediate symptoms?	24%	32%
54	For those who had been seen by health care, would you rate the quality as good/very good?	21%	28%
55	Do you have any specific physical health care needs?	40%	33%
56	Do you have any specific mental health care needs?	16%	24%