



Inspecting policing in the public interest

Report on an announced inspection visit to police custody suites of the

# British Transport Police

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

**17 – 20 March 2014**

**Glossary of terms**

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/



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

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# Section 1. Introduction

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

British Transport Police (BTP) had recently undertaken a substantial restructuring. BTP once had custody suites at key points in England, Wales and Scotland, but had taken a strategic decision to close these suites and to take people to the appropriate local force custody suite to be detained. The only suites that remained under the control of BTP were in London. We inspected two weeks before the new structure was fully implemented in London.

BTP polices Britain's railways, providing a service to rail operators, their staff and passengers across the country. They were largely funded by the train operating companies, Network Rail, and the London Underground – part of Transport for London. The nature of detainees varied enormously, from people detained for vagrancy, fare evasion, mental health related issues leading to offending behaviour, immigration and public order offences. Many people detained were passing through and therefore presented a different set of issues to those faced by local police.

It was not easy for BTP to identify strategic partners because of the transient nature of the population; however they developed good partnerships with the Metropolitan Police Service.

Practice varied across the suites, but overall there was good detainee care. Detainees were held in clean and well maintained facilities and staff treated them respectfully. Staff received custody specific training before working in custody and there was effective audit and inspection, including a detailed learning lessons procedure. The pre-release risk assessments (PRRAs) were not always completed and it was not clear how vulnerable detainees reached home. We found this concerning.

BTP used an out-of- date list of interpreters or relied on contacting people who had previously left their business cards. Appropriate safeguarding checks and clearance to provide these services to vulnerable detainees could not be relied on.

Health care provision was adequate. The designated medical rooms were clean, suitably equipped and clinically satisfactory. Paper clinical records were satisfactory and welfare plans reflected key risks and relevant information. BTP custody was rarely used as a place of safety for people with mental illness.

This report provides a number of recommendations to assist the force and the Police Authority to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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HM Chief Inspector of Prisons

September 2014

# Section 2. Background and key findings

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

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

**2.3** British Transport Police (BTP) polices Britain's railways, providing a service to rail operators, their staff and passengers across the country. They also police the London Underground, Docklands Light Railway, the Midland Metro tram system, Croydon Tramlink, Sunderland Metro, Glasgow Subway and Emirates Airline. About 95% of BTP's funding comes from the train operating companies. It is also funded by Network Rail, the London Underground (part of Transport for London) and other operators with whom the BTP has a service agreement. This funding arrangement does not give the companies power to set objectives for the BTP, but industry representatives serve as members of the police authority. BTP had been undertaking a substantial restructuring, including a reduction in the number of custody suites, to be completed by 1 April 2014. At the time of the inspection, BTP had five custody suites open in London and had closed other non-designated suites around the country. West Ham custody suite was closed during the inspection for refurbishment.

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|---|---|
| Brewery Road | 20 cells |
| Central London | 10 cells |
| Ebury Bridge | 4 cells |
| Hammersmith | 4 cells |
| West Ham | 4 cells – closed for refurbishment |
| Wembley Park | 8 cells – opened for events |

**2.4** We examined the custody strategy, treatment and conditions, individual rights and health care in the custody suites. During the year March 2013 to February 2014, 8,790 detainees had been held in the suites.

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

## Strategy

**2.5** The force had a clear strategic focus on the safe and decent delivery of custody. During the previous two years they had rationalised their custody facilities which now only remained in London.

**2.6** BTP had a good procedure for the management of identified custody risks. Performance management information, including complaints and early intervention reports, was used to improve detainee care. Early interventions are sometimes known as 'near miss' incidents, where something more serious would have happened were it not for the intervention of another person. A custody audit/inspection process was linked to College of Policing Authorised Professional Practice guidance and themes from our inspection reports on other forces.

**2.7** BTP were not able to identify strategic partners because of the transient nature of the population. They had a good partnership with the London Criminal Justice Board and shared independent custody visitors with the Metropolitan Police Service, which was appropriate. The head of the custody directorate attended relevant custody forums. Some strategic work was needed to ensure that local authorities provided overnight accommodation for young people charged and refused bail, which, according to staff, was never available.

**2.8** Staff received custody-specific training before working in custody, with annual refresher courses. Staff told us they valued this training and found it useful. Lessons from early interventions and Independent Police Complaints Commission (IPCC) investigations were incorporated into refresher training. There was a comprehensive quality assurance procedure: managers randomly sampled a number of custody records each month in each suite, with oversight by headquarters staff.

**2.9** We found staffing to be adequate, with the exception of Brewery Road where we witnessed instances of inadequate staffing levels to the point where detainee care suffered (see section on treatment and conditions and safety). The structure of BTP at the time of the inspection did not allow for much staff movement between sites.

## Treatment and conditions

**2.10** Detainees were treated with respect but in some cases police deployed to escort the detainee to the custody suite took too long. All the suites provided privacy at the booking-in desks. Management of tasks in the custody suite at Brewery Road was at times poor, compounded by inadequate staffing. At all four suites we saw some good interactions between detention officers and detainees. Women were not asked during the booking-in process if they wanted to speak to a female officer, but we saw instances when female staff were identified to care for women in custody, which was good. Facilities for detainees with disabilities varied and were best at Brewery Road. All the suites had hearing loops and staff knew how to use them. There was very good provision of religious texts in all four custody suites and they were appropriately stored. Staff had a good awareness of respecting detainees' culture, religion and gender while conducting searches and of the implications of holding young people in custody.

**2.11** Custody staff were competent to assess and manage most risks presented by detainees. They undertook a thorough risk assessment and explained clearly what they were asking if detainees did not understand. However, all jewellery, shoes and cords were routinely removed from all detainees. A range of levels of observation were used and reviewed, but there was no consistent method of ensuring that information was accurately recorded and communicated to custody staff. Custody staff responded well to the potential risks posed by

detainees and there was evidence of dynamic risk assessment and a reduction in rousing measures. Not all staff carried ligature knives and there was a shortage of keys at Brewery Road which posed a risk to detainee care.

**2.12** Pre-release risk assessments (PRRAs) were not always completed and we were concerned that arrangements to ensure the safety of vulnerable detainees, when released, were not always clear. The support leaflets held at different suites were not consistent and Ebury Bridge was the only suite to provide travel warrants.

**2.13** Staff were aware of the need to record use of force, but trends were not identified adequately. Not all detainees were handcuffed, but some detainees who were compliant remained in cuffs for too long while waiting to be booked in to custody.

**2.14** All the cells were clean and well maintained. At some suites we observed officers placing detainees in cells without showing them where the call bells were. Call bells sounded clearly and were answered promptly. There were enough handcuffs in each suite to facilitate a safe evacuation in the event of a fire and there had been practice evacuations in all suites in the previous six months.

**2.15** There were good stocks of clothing and underwear and clean cotton towels. Hygiene packs were available, but not routinely offered, and detainees had to ask for toilet paper. Private showers with hot water were available. There were plenty of clean blankets, mattresses and pillows which were sanitised between uses, but not all suites had anti-rip blankets. Some detainees were offered reading material. Some suites held stocks of magazines and books in foreign languages for young people and adults. Microwave meals were offered when necessary. The exercise yards at Brewery Road and Hammersmith were dirty and were used by staff to smoke, despite notices to the contrary. There was no exercise yard at Central London or Ebury Bridge. Detainees were allowed visits depending on individual circumstances, which was commendable.

## Individual rights

**2.16** Arresting officers explained reasons for arrest and detention, however some sergeants felt their role was to support front-line staff rather than separately ascertain reasons for detention. Alternatives to custody, such as voluntary attendance, were used. Immigration detainees were moved on quickly after an IS91 (authority to detain notification) had been served, but staff said that many detainees were held for immigration matters for up to 14 to 15 hours, when they were served with an IS96[2].

**2.17** A professional appropriate adult service was available for young people and vulnerable adults. Custody staff said that a good service was provided but there were sometimes delays at night. Telephone interpretation services were available through Language Line, and face-to-face interpretation was also provided. However, we were concerned that the force was using an out-of-date list of interpreters or relied on interpreters leaving their business cards, so there was no assurance that they had appropriate safeguarding checks or clearance. Rights and entitlements documents were available in foreign languages on the force intranet site, which staff could easily access, but some versions of the document were out of date.

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[2] Under the Immigration Act 1971, IS96 is a notification of temporary admission to a person who is liable to be detained. This requires the individual to stay at a particular address and periodically report to the Home Office enforcement offices or a designated police station.

**2.18** None of the suites had facilities for detainees to speak privately on the telephone to their legal representatives. There were sufficient clean and private interview rooms and solicitors were offered a photocopy of detainees' custody records on request. Not all suites had copies of the new Code C Code of Practice[3]. There were sometimes delays in processing detainees because police units disagreed on which department should deal with the detainee. Responsibility for investigating the matter was ambiguous and protocols required custody officers to contact the original officers, so matters became delayed as they decided who should deal with the detainee. PACE reviews were thorough. If reviews were delayed, this was noted in a separate entry in the custody record.

**2.19** Detainees were provided with information on how to make a complaint. IPCC complaints leaflets were available in all suites, but it was unclear if they were handed out.

## Health care

**2.20** BTP had a contract with Tascor to provide primary care services to custody, which they monitored carefully. Tascor had very few permanent staff, with the risk that staff brought in from other contract areas would be unfamiliar with custody. There were designated health rooms in the four suites which were clean, suitably equipped and clinically appropriate. Paper clinical records were reasonable and the custody medical and welfare plans reflected key risks and appropriate information. All detainees whom we saw were asked whether they would like to see a health care professional. The average waiting time for a health care professional was reported at 1 hour 20 minutes, which was too long. Consultations were clinically appropriate and we observed some thoughtful care. Detainees were able to have most prescribed medication verified and administered and there was a good system for detention officers to give over-the-counter analgesia. Detainees prescribed opiate substitution were not able to receive it while in custody.

**2.21** Detainees who disclosed substance misuse problems or showed withdrawal from drugs or alcohol were screened and given symptom relief as appropriate. They were not able to see a substance misuse worker.

**2.22** No mental health services were contracted to the custody suites. Staff relied on emergency duty teams and there were sometimes long delays for mental health assessments. Less than 3% of all Section136[4] detentions came to the custody suites, which was commendable.

## Main recommendations

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

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[3] Code C of the Police and Criminal Evidence Act 1984 sets out the requirements for the detention, treatment and questioning of suspects in police custody other than in terrorism cases to which code H applies.
[4] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety - for example a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker and for the making of any necessary arrangements for treatment or care.

**2.24 Custody sergeants should ensure detention is appropriate and last for no longer than is necessary.**

**2.25 Procedures for contacting face-to-face interpreters should be reviewed to ensure that they are appropriately vetted individuals and suitably qualified. The interpreters list should be up to date.**

# Section 3. Strategy

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

## Strategic management

**3.1** British Transport Police (BTP) was a national police force and their officers made arrests across the country, although, with the exception of London, not enough to justify dedicated full-time BTP custody suites. In these cases, officers took detainees to a custody suite in the police force area where the arrest was made.

**3.2** An assistant chief constable (ACC) provided strategic leadership on custody issues. Delivery of custody for BTP was devolved to division, under the leadership of a superintendent. A headquarters-based custody directorate was responsible for custody policy and offender management. The force had recently carried out a strategic review and was in the process of changing the divisional structures, moving to one division in London, which was to take place on 1 April 2014. A police authority member was responsible for overseeing custody issues and had regular meetings with the ACC and the head of the custody directorate.

**3.3** As part of the strategic review, the force had closed a number of non-designated custody suites across the country, leaving five full-time suites in London, with a further suite at Wembley Park for use as a standby suite or for specific operations.

**3.4** Staffing levels in custody suites were adequate, with the exception of Brewery Road, where custody staff were working at full capacity. This affected their ability to deliver a safe service, (see also paragraph 4.17). There was very little movement of staff between suites to cover for absences or to meet unexpected demand. Staff included permanent custody sergeants and designated detention officers (DDOs) employed by BTP. Other sergeants who were trained in custody were used as back-up for permanent custody sergeants. We were told that police constable gaolers who had not received custody-specific training were occasionally used.

**3.5** DDOs were responsible for the care and welfare of detainees. They provided a good standard of care and were professional and positive in their role.

**3.6** Three dedicated custody managers were responsible for the management of BTP custody suites, line management of custody staff and Police and Criminal Evidence Act issues. Line management arrangements for permanent custody staff were clear.

**3.7** A sound meeting structure included a force custody steering group, chaired by the ACC, which met every six months and monthly custody manager meetings, chaired by the divisional lead for custody. Minutes of the meetings showed that they were well attended and that actions were regularly reviewed. Issues discussed included lessons learned, good practice, strategic risks, complaints and training. Custody managers held informal meetings with staff at a local level.

**3.8** In late 2013, the force had stopped using their custody IT system and moved to paper custody records, while sourcing a new IT system. A good range of performance management information was used to monitor areas such as throughput, disposals and occupancy rates

and was discussed at monthly custody manager meetings, the force custody steering group and police authority meetings.

## Partnerships

**3.9** The British Transport Police Authority had an arrangement with the Mayor's Office for Policing and Crime (MOPAC), for independent custody visitors (ICVs) from the MOPAC ICV scheme to visit BTP custody suites in their respective boroughs. This arrangement worked well, and ICVs and MOPAC coordinators reported a good relationship and said that issues identified during visits were resolved promptly. Custody managers regularly attended ICV panel meetings and the outcomes of ICV visits were discussed at custody manager meetings.

**3.10** There were good partnership arrangements through the custody directorate, for example, the head of the directorate attended the London Criminal Justice Board on behalf of the ACC. However, we were told that local authority accommodation was not available for young people charged and refused bail: this needed to be addressed at a strategic level.

## Learning and development

**3.11** All custody sergeants undertook custody-specific training before assuming custody duties. The training was linked to the national custody officer learning programme (NCOLP) delivered by the College of Policing. DDOs took a four-week initial custody course linked to the NCOLP, adapted to their learning requirements and based on safer detention principles. This training included an attachment to a custody suite.

**3.12** Annual refresher training, specific to role, was available for custody sergeants and DDOs and staff told us they valued this training. Records showed that most staff had undergone this training. There was good oversight of training.

**3.13** There was an embedded custody audit/inspection process in place, and each custody suite was inspected three times a year. This was coordinated by the custody directorate and included representatives from health and safety and facilities. It was linked to the College of Policing Authorised Professional Practice guidance on detention and custody and themes and recommendations from HM Inspectorates of Prisons and Constabulary custody inspection reports. Custody managers were responsible for action plans which were produced after each audit and reviewed at custody manager meetings. These processes resulted in a clean and safe environment for detainees.

**3.14** A detailed and effective procedure was in place for recording and learning from near misses, known as early intervention reporting. Custody sergeants completed a computer-based form, which was communicated to the custody manager, custody directorate, health and safety department and Police National Computer bureau. Early intervention reports were referred to the professional standards department as appropriate following assessment. Information and trends from these reports were discussed at the custody manager meetings. Learning from these incidents was communicated to staff and, where appropriate, included in custody training.

**3.15** There was a comprehensive quality assurance procedure. Custody managers were expected to sample randomly 10% of custody records a month for each suite. This included person escort record forms and CCTV recordings, but not shift handovers. Custody managers told us that they routinely monitored handovers, but this was not recorded. There was good

oversight and monitoring of the quality assurance procedure by the custody directorate, and trends and learning were regularly published in custody bulletins.

**3.16** There was a well designed custody intranet site, which was accessible and contained useful information, such as custody briefing notes and IPCC 'learning the lessons' bulletins. Some staff told us they did not use the site regularly.

## Recommendations

**3.17 Staffing levels should be reviewed to ensure that sufficient custody staff are on duty at all times to meet demand.**

**3.18 Police constables who are used as gaolers should receive training in the role before working in custody.**

**3.19 The lack of local authority accommodation for children and young people refused bail at police stations should be resolved at a strategic level with local authority partners.**

## Housekeeping points

**3.20** The BTP police authority should ensure, through liaison with the Mayor's Office for Policing and Crime, that there are regular ICV visits to all BTP custody suites.

**3.21** Shift handovers should be included in the quality assurance procedure.

# Section 4. Treatment and conditions

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

## Respect

**4.1** Detainees were treated respectfully and considerately in all four custody suites. Detention officers, in particular, were reassuring to detainees and responded appropriately to their requests. The custody suites offered very good privacy at the booking-in desk. Each terminal was well screened which allowed more than one detainee to be booked in at a time with enough privacy to reply to personal questions during the risk assessment.

**4.2** Detainees could be taken to non-BTP custody suites, but, despite this, we saw people who had been arrested brought from various parts of London to Central London Police Station (CLPS). One detainee had been arrested in Whitechapel at 8.40am and arrived at CLPS at 10.20am after a journey of over an hour because of heavy traffic. This was too long given the alternative options and staff told us that this happened regularly.

**4.3** The management of the custody suite at Brewery Road was poor at times. This was compounded by a shortage of staff to care for detainees and undertake a range of tasks, including answering intercoms and admitting non-custody staff to the building. Detainee care suffered as a result (see section on safety).

**4.4** Girls aged 16 or under were not allocated a named female officer with responsibility for their care and women coming into custody were not routinely asked if they wanted to speak to a female officer. We did observe a detention officer escorting a female detainee to her cell and reassuring her that, if she felt more comfortable speaking to a female officer, this could be arranged. All women were asked if they might be pregnant so that they could be appropriately cared for.

**4.5** Overall facilities were adequate; facilities for detainees with disabilities were basic in most suites. Brewery Road had an adapted shower and toilet and a cell with a lowered call bell, although the bell was near the door and not always accessible to detainees from a seated position. All suites had hearing loops, which staff knew how to use, and the other three suites had thick mattresses for detainees who might find the bed plinths too low.

**4.6** Detention officers we spoke to were able to explain the steps they would take if a young person or adult made an allegation of abuse, and they had received relevant training. There was no policy limiting the detention of children and young people but custody sergeants in all suites told us that they were held for the minimum time because of their vulnerability. Our analysis of custody records showed that three young people had been held for six hours or less and had been supported by appropriate adults (see section on individual rights). Two detention rooms for young people at CLPS were located close to the booking-in area. We observed one young person returning to answer his bail. The custody officer used age-appropriate language and the appropriate adult waited with the young person on a bench in the booking-in area.

**4.7** There was a good range of religious material and equipment in all four custody suites, appropriately stored. Cells were marked with the direction of Mecca. Staff had a good awareness of conducting searches while respecting the culture, religion and gender of

detainees. We saw all detainees being asked if they had any dependency obligations and any issues raised by detainees were responded to appropriately.

## Recommendations

**4.8 Detainees should be taken to the police station nearest to the place of arrest to avoid long escort times to a BTP custody suite.**

**4.9 The cell call bell should be relocated so that detainees with disabilities can use it from a seated position.**

**4.10 Women should be asked if they would like to speak to a female officer and this should be facilitated.**

## Housekeeping point

**4.11** Girls aged 16 or under should be allocated a female officer with responsibility for their care.

## Safety

**4.12** Custody sergeants and designated detention officers (DDOs) booked in detainees and asked them about their health, risks and individual needs. Not all staff had access to the police national computers but checks were conducted by the arresting officer or a DDO and warning markers concerning detainees' risks formed part of the risk assessment. We saw custody staff asking appropriate supplementary questions when detainees disclosed potential risks. Custody staff explained sensitively questions that detainees did not understand and provided reassurance throughout the booking-in process. We found the risk assessments to be thoroughly conducted. This was reflected in our analysis of custody records which showed that all detainees were risk assessed on arrival and that the assessments were detailed and of good quality. However, detainees' risk was not managed proportionately: jewellery, shoes and clothes with cords were routinely removed.

**4.13** Children and young people were placed on 30-minute observations, which was appropriate. A range of levels of observation were used and reviewed but some of the records that we examined indicated that there was no consistent system for ensuring that information was accurately recorded and communicated to custody staff. The level of observation was not always entered in the relevant document and we found information about a detainee's risk in places which were not easily identifiable, including the custody log. If a detainee was placed on 30-minute checks with rousing, the frequency of visits was recorded but not the fact that the detainee needed to be roused. Confirmation in the risk assessment that the detention officer had been made aware of the level of observation to be conducted was not always signed. However, in general staff responded well to the potential risks posed by detainees.

**4.14** Intoxicated detainees were subject to rousing checks and appropriately cared for. Those who were of most concern were referred to the health care professional. The 4-Rs mnemonic (rousing procedure set out in annex H to code C in the Police and Criminal Evidence Act 1984) was available in the custody suites and custody staff understood the importance of obtaining a response.

**4.15** We did not observe any constant supervision of detainees during the inspection but DDOs we spoke to gave a good account of how they had conducted a constant supervision, and said that they were fully briefed by the custody sergeant and recorded anything of significance.

**4.16** All cells in the four custody suites were monitored by CCTV. Not all staff carried ligature knives. At Ebury Bridge staff had not been issued with ligature knives, which posed a risk to detainee care.

**4.17** There needed to be more control of non-custody staff accessing detainees in their cells without supervision or authorisation being sought from custody sergeants. We observed non-custody staff taking cell keys and visiting detainees, which was not appropriate. At Brewery Road custody staff could not locate a detainee, who they thought was in his cell. It transpired that an officer had taken the keys to unlock the detainee, without notifying the custody sergeant or recording that the detainee was being taken out of his cell for a consultation with his solicitor. There were risks associated with arresting officers having unsupervised access to detainees. Officers did not have training in dealing with detainees in custody, they did not carry ligature knives and there were no safeguards for detainees or officers against potential allegations.

**4.18** The handovers that we observed involved the whole team. Relevant information was shared, with a good focus on risk information. At Brewery Road a handover highlighted that a detainee's review had been missed and that a detainee who had been released had some property belonging to another detainee, which was not returned. This further reflected that the management of the custody suite was not effective and that one custody sergeant and two detention officers could not deal with all the demands. We observed custody records being thoroughly read before the incoming custody sergeant accepted responsibility for the care of the detainees.

**4.19** The level of detail in pre-release risk assessments (PRRAs) varied and in some cases it was unclear if detainees' vulnerabilities had been effectively addressed. There was no indication that detainees released during the night were able to travel home safely, which was concerning. We observed one female detainee being released. The pre-release document was not completed with her but an officer gave her a map to get home and answered all her questions about her bail conditions. Different support leaflets were available across the four suites. The leaflet at Brewery Road was the most detailed but none was available in other languages. It was unclear why travel warrants were only available at Ebury Bridge.

## Recommendations

**4.20 Non-custody staff should not have access to cell keys and visits to cells should be undertaken only by custody staff, or, if necessary, accompanying other staff.**

**4.21 Travel warrants should be available at all the custody suites.**

## Housekeeping point

**4.22** Information about support agencies should be available in several languages.

## Use of force

**4.23** Not all detainees arrived at the custody suite in handcuffs, which was commendable. But the few detainees who were remained in handcuffs too long while waiting to be booked in or to enter the suite. Police staff did not consider removing them even when detainees appeared compliant.

**4.24** We did not observe authorities for any strip-searches authorised during the inspection. In our custody record analysis, five (17%) detainees in our sample were strip-searched while in custody, apparently because of warning markers identified from police national computer checks. In all instances authorisation was recorded in the detainee's record.

**4.25** Staff told us that they only referred a detainee to a health care professional after the use of force, if there were obvious signs of injury. There was insufficient analysis of use of force information to identify any trends. Forms were monitored by the personal safety trainer to identify training needs. All staff had been trained in approved safety techniques and received annual refresher training.

## Housekeeping point

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

## Physical conditions

**4.27** The four custody suites were in very good condition. Most had been redecorated and deep cleaned recently. Ventilation was reasonable and cells with no natural light, particularly at CLPS, had cell lights on throughout daylight hours. There was very little graffiti in the suites and it was evident that cleanliness of the custody suite was a priority for staff.

**4.28** Daily cleaning arrangements varied, but were thorough. In some suites the DDOs were responsible for cleaning the cells, except when bodily fluid spills needed cleaning. At other sites, cleaning contractors cleaned the whole suite, including the cells. Procedures for daily cell checks also varied. For example, Ebury Bridge cells were checked by the morning shift, while at other suites each shift conducted a cell check, which we observed being thoroughly carried out at CLPS by DDOs. An additional check was made when a detainee was placed in a cell, paperwork was completed and placed with the detainee's custody record.

**4.29** At Hammersmith cell doors with T-bar handles posed a significant ligature risk if the cell door hatch failed or was left open. At Ebury Bridge the water dispenser buttons were protruding but the potential risk was not identified during daily cell checks. The force was made aware of these issues at the two custody suites.

**4.30** At some suites we observed police officers escorting detainees to the cells without showing them where the call bells or any equipment were located. Cell call bells sounded clearly and were responded to promptly by custody staff. There were enough handcuffs in all the suites to facilitate a safe evacuation in the event of a fire. We were told that there had been practice evacuations in all suites in the previous six months but records of these were not kept in the custody suites.

## Housekeeping points

**4.31** Recorded cell checks should take place daily across the custody suites.

**4.32** The cell call bell should be explained to detainees when they are located in a cell.

**4.33** Emergency practice evacuations should be recorded and a copy kept in the custody suites.

## Detainee care

**4.34** Each cell contained a pillow and mattress which were in good condition and clean. Toilet paper was only provided on request. Hygiene packs for female detainees were available but not routinely offered. Clean showers in all the suites afforded reasonable privacy but according to our custody record analysis, were not always offered. There were good stocks of clean towels and toiletries.

**4.35** Detainees who did not want the cords cut from their clothes were routinely given a tracksuit to wear. There was a good supply of replacement clothing in a range of sizes, including underwear and plimsolls, and enough blankets. Some suites had anti-rip blankets. Detainees were required to leave their shoes outside their cells. At Ebury Bridge clothes for a court appearance were handed in for a detainee who had been in custody over the weekend.

**4.36** There were sufficient microwave meals at all suites, to meet a range of dietary needs, including halal, vegetarian and gluten free. The meals were of low calorific value and staff told us, and we observed, that they would provide more than one meal on reasonable request. Our analysis of custody records indicated that 19 detainees (63%) were offered at least one meal. However, 11 detainees (37%) in the sample were not offered meals, the longest having been held for 15 hours 32 minutes, which was concerning. We observed custody staff regularly offering hot and cold drinks.

**4.37** Detainees could use exercise yards at Hammersmith and Brewery Road without supervision, subject to risk assessment, and all the yards were monitored by CCTV. All the yards were dirty. A notice at Brewery Road reminded staff that the yard was for detainees' use and was not a smoking area for staff. Records in our sample showed that no detainee had been offered exercise. There were no exercise yards at the other two suites and staff told us that if a detainee asked for some air they used the vehicle dock. This was not appropriate, particularly at Ebury Bridge where the van dock was overlooked by residential properties.

**4.38** There was a reasonable stock of books and magazines for young people and adults at CLPS and Brewery Road, including some in foreign languages. We saw reading material being offered to detainees. At Ebury Bridge there was only one foreign language book and very little for young people and at Hammersmith the limited reading material was only available in English. Detainees were allowed visits depending on individual circumstances, and a detainee who had been in custody over the weekend was permitted a visit from his partner.

## Recommendations

**4.39 Detainees should be offered sufficient food and drink.**

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

## Housekeeping points

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

**4.42** All detainees held overnight, or detainees who require it, should be offered a shower, which they can take in private.

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

# Section 5. Individual rights

**Expected outcomes:**
**Detainees are informed of their individual rights on arrival and can freely exercise those rights while in custody.**

## Rights relating to detention

**5.1** Arresting officers explained the circumstances and reasons for the arrest to custody sergeants before they authorised detention. Some custody sergeants told us they never refused detention because they expected the arrest to be lawful and their role was to support these officers. Other custody sergeants said that they had occasionally refused to detain when they thought the arrest was unnecessary, usually on health grounds. Custody sergeants should always review the reason and necessity for arrest and not assume their role is to support the arresting officer.

**5.2** Alternatives to custody, such as voluntary attendance, were available, and staff said that they were being used more frequently[5]. Records at Ebury Bridge and CLPS showed that from 1 January to 17 March 2014, 25 and 28 voluntary attendances had been recorded compared with 41 and 75 respectively for the whole of 2013. The procedure for using voluntary attendance varied, for example at Ebury Bridge, officers had to book a slot in the bail diary to use the custody suite interview facilities, which was not the case at the other suites.

**5.3** We were told that detention was occasionally delayed because investigation protocols required custody officers to contact police units which dealt with the relevant offence. Responsibility for investigating the matter could be ambiguous and we saw one case which could have been dealt with much more quickly. However, custody sergeants generally ensured that cases proceeded quickly and we observed most cases being dealt with promptly. Our sample of 30 custody records indicated an average length of detention of 8 hours 56 minutes. Twelve of these detainees, including three aged under 17, had been held for less than six hours.

**5.4** Custody staff reported a reasonable relationship with Home Office Immigration Enforcement and said that immigration detainees, who were to be transferred to immigration removal centres, rarely remained in the custody suites for longer than 24 hours. This was not the case for 'non-removal' immigration detainees who were held for up to 15 hours with no attendance by enforcement officers. An IS96 document was faxed to custody staff, which enabled the immigration detainee to be released with instructions to report to the Home Office Immigration Enforcement office. It was unclear why they were held in custody for so long and not issued with release documents more quickly.

**5.5** Staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989[6].

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[5] Usually for lesser offences when suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.
[6] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

**5.6** Custody staff were aware of their responsibility to contact an appropriate adult (AA) for vulnerable adults or young people under 18 years of age. Family or friends were contacted in the first instance and the force had a document explaining their role and responsibilities as an AA, which not all staff were aware of. If it was not possible to contact a relative, all custody suites had an arrangement with a professional service to provide an appropriate adult for young people and vulnerable adults. Appropriate adults were present while three young people in our custody record analysis were interviewed and read their rights.

**5.7** Most staff said that the AA service was good but delays could happen between 11pm and 9am. Records showed that a man with mental health issues had been seen by a health care professional, who had identified his need for the support of an AA. Staff contacted the service at 10pm and left a message but, despite further attempts, the AA did not arrive until 10am.

**5.8** Staff said that it was not common for children and young people under the age of 18 to be detained and they preferred to bail a child or young person to return to the police station at a later date, rather than keep them overnight. If this was not possible, custody staff requested secure Police and Criminal Evidence Act (PACE) beds from local authorities when a young person had been charged and could not be bailed, but they had never known beds to be available.

**5.9** Helpful interpretation service posters at all suites enabled non-English speaking detainees to indicate their language. A professional telephone interpretation service was available for the booking-in process, which we saw being used to good effect. Ebury Bridge and Brewery Road only had loudspeaker telephones, which lacked privacy, while the other two suites had a telephone with two handsets on the booking-in desk. At Brewery Road an interpreter was asked to carry out the initial rights and entitlements process over the telephone with a detainee. The interpreter was not advised of what questions to interpret but conducted the discussion with the detainee, with no input from staff. We could not confirm that the detainee had been advised of her rights and entitlements.

**5.10** Staff said that a good face-to-face interpretation service was available for interviews, but at Ebury Bridge, staff used interpreters' details from a 2007 printed list and at Brewery Road interpreters' business cards were used to identify contact telephone numbers. These methods did not provide an assurance that the individuals were suitably qualified or had the necessary vetting clearances. At three of the four suites we saw interpreters in attendance for interviews and charging/release purposes. Custody staff asked them to provide a written translation of essential documents, such as charge and bail details, in the detainee's first language, which was helpful.

**5.11** During booking in, custody staff advised detainees of their three rights to have someone informed of their arrest, to consult a solicitor for free independent legal advice, and to consult the codes of practice. At some custody suites the written notice setting out these rights and entitlements was out of date. Custody staff were aware that a similar version could be downloaded from the custody intranet and printed in their own language for non-English speaking detainees. None of the custody staff was aware that there was an easy-read pictorial format version of detainees' rights and entitlements on the Home Office website. The rights and entitlements documentation was not available in braille in any of the custody suites.

## Recommendation

**5.12 Appropriate adults should be available at all times for young people and vulnerable adults.**

## Housekeeping points

**5.13** British Transport Police should ensure that there are no unnecessary delays in progressing detainees` cases because of the investigation protocols.

**5.14** Custody staff should be made aware of the guide on the role and responsibilities of family or friends acting as an appropriate adult.

**5.15** Double-handset telephones should be provided in all suites to facilitate telephone interpretation.

**5.16** Detainees should be offered a written notice of the up-to-date version of their rights and entitlements.

## Rights relating to PACE

**5.17** Criminal Defence Service (CDS) posters advising detainees of their right to free legal advice were displayed in English at Hammersmith and Ebury Bridge. CLPS had posters in other languages but there were no CDS posters at Brewery Road.

**5.18** We observed detainees being told of their right to free legal advice and, in our custody record analysis, all detainees had routinely been offered legal advice, 16 of whom (53%) had accepted this offer. All records indicated that solicitors were contacted promptly on request. Detainees who declined legal services were asked the reason and told they could change their mind at any time. At all suites, detainees could only consult legal advisers by telephone at the custody desk, which lacked privacy. We observed legal advisers being routinely offered a photocopy of custody records for inspection. All suites had enough consultation and interview rooms.

**5.19** In most of the custody records that we reviewed, it was clear that the nominated person had been informed. Half the detainees in the sample (15) were able to make a telephone call while detained and we observed this routinely during the booking-in process. Detainees were told they could read the PACE codes of practice, but these were not routinely shown or explained by custody staff. Up-to-date copies were not available at Ebury Bridge or Brewery Road.

**5.20** Reviews of detainees in custody were undertaken by dedicated custody and operational inspectors across the force. We observed some thorough face-to-face reviews. Staff told us that many PACE reviews were carried out over the telephone because of the distance between custody suites and the difficulty in travelling across London. Our record analysis showed that a number of face-to-face and telephone reviews (initial reviews) were appropriately conducted. If reviews were delayed, this was noted in a separate entry in the custody record.

**5.21** DNA samples in the custody fridge at Brewery Road were over a week old and staff were unsure of the collection arrangements. At other suites there appeared to be an effective system to ensure that DNA samples taken in custody were collected regularly. Most detention officers were aware of the Force's policy on the retention and disposal of DNA samples.

**5.22** The latest times that courts would accept detainees from police custody varied. BTP custody suites detained arrested people from throughout London, and we observed detainees who were subsequently escorted to different courts throughout the city. Staff told us that some

courts refused to accept a detainee after 11am, others up to 3.30pm on a weekday. On Saturdays, these times varied from 10am to noon.

## Recommendation

**5.23 Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary.**

## Housekeeping points

**5.24** Posters concerning detainees' right to free legal advice should be prominently displayed in a range of languages in all custody suites.

**5.25** Detainees should be able to have a private telephone consultation with their legal adviser.

**5.26** Sufficient up-to-date copies of the PACE codes of practice should be made available at all custody suites.

**5.27** PACE reviews should be carried out on time.

## Rights relating to treatment

**5.28** The notice of rights and entitlements offered to all detainees when they were booked in described how to make a complaint. Custody staff said that if a detainee wished to make a complaint, they advised the custody inspector or duty inspector immediately. Inspectors said they would take the complaint while a detainee was still in custody, depending on the nature of the complaint and their availability. All suites had copies of the Independent Police Complaints Commission (IPCC) leaflet on how to make a complaint. At Brewery Road, telephone numbers, website addresses (BTP and IPCC), and the addresses of the custody suite and the professional standards department, were readily available for issue to detainees.

# Section 6. Health care

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

## Governance

**6.1** Health services were commissioned by British Transport Police (BTP) and had been provided by Tascor since November 2013. The BTP custody manager had management oversight of the contract, including monthly meetings. Joint working between health and custody staff was very good.

**6.2** Governance was reasonable but 24-hour staffing of the four suites was compromised by recruitment delays and the regular use of agency staff. The lead forensic medical examiner (FME) and forensic nurse practitioner (FNP) provided regular clinical cover, but this was not sustainable.

**6.3** Designated health rooms in the four suites were clean and situated near the custody desks. All suites had suitable clinical waste bins and sharps disposal. Two of the suites had no sink and one suite had no elbow taps on the sink. There were lockable wall and floor storage cupboards. Some emergency buzzers were poorly located. Rooms were accessible to custody staff but equipment was locked away. At CLPS, the chairs in the treatment room were bolted to the floor and poorly positioned.

**6.4** New resuscitation kits were kept in all the suites and clinical equipment. Automated defibrillators were kept by the custody desks and checked by the detention officers each day.

**6.5** A paper clinical record system was used. Records were reasonable and the custody medical and welfare plans reflected key risks and appropriate information. Clinical records were stored in locked filing cabinets and at Ebury Bridge in the medicine cabinet.

**6.6** Algorithms and escalation protocols were visible in the suites and there were some good templates for assessment and handover to accident and emergency, including information-sharing consent. There was no formal procedure for contacting mental health services (see section on mental health).

**6.7** Forensic kits were stored in locked cupboards and were all in date.

**6.8** Nurses we spoke to were either agency staff or had not received an induction. There were not enough staff to allow for training and development or clinical supervision.

## Recommendation

**6.9 Safe staffing levels should ensure that all detainees are assessed by properly trained and skilled staff who are familiar with the four suites.**

## Housekeeping point

**6.10** Emergency buzzers in the treatment rooms should be located to ensure staff safety and chairs should be movable.

## Patient care

**6.11** All detainees whom we saw were asked if they would like to see a health care professional, and detainees with identified injuries, illnesses, mental health or substance use withdrawal needs were assessed by a health care professional. The average waiting time for a health care professional was reported at 1 hour 20 minutes, which was too long. Custody staff said that response times had improved in the last three months and that staff seemed to spend more time with detainees.

**6.12** Consultations that we observed were clinically appropriate and we saw some thoughtful communication with and care of detainees. However, we raised concerns about the attitude of one FNP towards detainees, with Tascor, and the same nurse said he always left the treatment room door open while assessing detainees, regardless of any identified risk which compromised confidentiality.

**6.13** We noted variability in risk assessment and care. Recent clinical records that we reviewed demonstrated attention to key risks and follow through on intoxication, opiate withdrawal and possible head injuries. An audit of head injury care was being conducted. However, in our analysis of retrospective custody records, three detainees had not seen a health care professional when they should have done. Two had been restrained at the time of arrest or in custody and the third had injuries consistent with an alleged head butting. Although the detainee said he had no pain to the head, he was also heavily intoxicated.

**6.14** Handovers to custody staff were thorough and the custody medical and welfare plan provided custody staff with adequate information about the detainees' health status and risks, together with fitness to detain and interview.

**6.15** Detainees being released were given an information sheet with details of national support services, but no local contacts.

## Recommendations

**6.16 Staff, including agency staff, should receive management supervision and training to ensure they understand their duty of care to detainees and their professional responsibility to communicate appropriately with detainees.**

**6.17 All detainees at risk of medical emergency, for example undetected head injury, should be assessed by a health care professional.**

## Medicines management

**6.18** Medicines belonging to detainees were initially stored with their property in sealed labelled bags in the locked property store. Appropriately labelled prescribed medication was verified and prescribed by FMEs and administered by FNPs; verified prescribed medicines were returned to the detainee on release.

**6.19** Detention officers were able to give over-the-counter pain relief after telephone confirmation with an FME. Detainees on methadone or other opiate substitution were not able to have this in custody and were given symptom relief as appropriate.

**6.20** Stock control and monitoring of controlled drugs was good and stock and running balances were recorded. We identified a minor variation in records at CLPS. All medicines, including controlled drugs, were kept in locked metal cabinets and access was restricted to health care professionals via a wall key safe in the treatment rooms.

## Recommendation

**6.21 Detainees should be able to have their prescribed opiate substitution while in custody**.

## Substance misuse

**6.22** Detainees were not able to see a substance misuse worker. Detainees who disclosed substance misuse problems or showed withdrawal from drugs or alcohol were screened using validated alcohol and opiate withdrawal screening tools. Paper copies of these were only available at Brewery Road.

## Recommendation

**6.23 Links with local drug and alcohol services should provide detainees with the opportunity to manage their addictions and receive continuity of care while in custody.**

## Housekeeping point

**6.24** Alcohol and opiate withdrawal screening tools should be available in all suites.

## Mental health

**6.25** There was no liaison and diversion scheme. We were pleased to see that custody suites were rarely used as a place of safety for people who were arrested under Section 136.

**6.26** There were no mental health services for the four custody suites and detainees needing assessment were referred to the relevant emergency duty team. Detainees with a history or signs of mental ill health were initially assessed by a health care professional and referred to the local service if required.

**6.27** We observed a lengthy delay for one detainee because a nurse was unsure whom to call and then had protracted telephone negotiations to get a team to attend. The team arrived within about half an hour of the PACE time limit expiring. There was no formal monitoring of response times by emergency duty teams.

**6.28** Some custody staff had little understanding of the distinction between 'bizarre behaviour' presentations and mental illness.

**6.29** The performance data showed that of all Section 136 detentions in 2013 (775) less than 3% (23) came into police custody. Custody sergeants' experience supported this. At Hammersmith we saw a female detainee who had attempted suicide, who was very intoxicated and displaying violent behaviour; she was looked after sensitively. The FME located the detainee's community mental health team and, following discussion with the emergency duty team when the detainee was calm and sober, she was transferred to the Section 136 suite in her local area. Care was taken to ensure that a female member of staff looked after her during her time in custody.

## Recommendation

**6.30 All custody staff should have mental health awareness training to improve their understanding of the distinction between behavioural traits, for example personality disorders, and mental illness so that they deal with detainees appropriately.**

# Section 7. Summary of recommendations and housekeeping points

## Main recommendations

**7.1** Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the detainee's position on release and any action that needs to be taken. (2.23)

**7.2** Custody sergeants should ensure detention is appropriate and lasts for no longer than is necessary. (2.24)

**7.3** Procedures for contacting face-to-face interpreters should be reviewed to ensure that they are appropriately vetted individuals and suitably qualified. The interpreters list should be up to date. (2.25)

## Recommendations

### Strategy

**7.4** Staffing levels should be reviewed to ensure that sufficient custody staff are on duty at all times to meet demand. (3.17)

**7.5** Police constables who are used as gaolers should receive training in the role before working in custody. (3.18)

**7.6** The lack of local authority accommodation for children and young people refused bail at police stations should be resolved at a strategic level with local authority partners. (3.19)

### Treatment and conditions

**7.7** Detainees should be taken to the police station nearest to the place of arrest to avoid long escort times to a BTP custody suite. (4.8)

**7.8** The cell call bell should be relocated so that detainees with disabilities can use it from a seated position. (4.9)

**7.9** Women should be asked if they would like to speak to a female officer and this should be facilitated. (4.10)

**7.10** Non-custody staff should not have access to cell keys and visits to cells should be undertaken only by custody staff, or, if necessary, accompanying other staff. (4.20)

**7.11** Travel warrants should be available at all the custody suites. (4.21)

**7.12** Detainees should be offered sufficient food and drink. (4.39)

**7.13** An appropriate exercise yard should be provided so that detainees, particularly those who are held for more than 24 hours, can be offered exercise. (4.40)

### Individual rights

**7.14** Appropriate adults should be available at all times for young people and vulnerable adults. (5.12)

**7.15** Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary. (5.23)

### Health care

**7.16** Safe staffing levels should ensure that all detainees are assessed by properly trained and skilled staff who are familiar with the four suites. (6.9)

**7.17** Staff, including agency staff, should receive management supervision and training to ensure they understand their duty of care to detainees and their professional responsibility to communicate appropriately with detainees. (6.16)

**7.18** All detainees at risk of medical emergency, for example undetected head injury, should be assessed by a health care professional. (6.17)

**7.19** Detainees should be able to have their prescribed opiate substitution while in custody. (6.21)

**7.20** Links with local drug and alcohol services should provide detainees with the opportunity to manage their addictions and receive continuity of care while in custody. (6.23)

**7.21** All custody staff should have mental health awareness training to improve their understanding of the distinction between behavioural traits, for example personality disorders, and mental illness so that they deal with detainees appropriately. (6.30)

## Housekeeping points

### Strategy

**7.22** The BTP police authority should ensure, through liaison with the Mayor's Office for Policing and Crime, that there are regular ICV visits to all BTP custody suites. (3.20)

**7.23** Shift handovers should be included in the quality assurance procedure. (3.21)

### Treatment and conditions

**7.24** Girls aged 16 or under should be allocated a female officer with responsibility for their care. (4.11)

**7.25** Information about support agencies should be available in several languages. (4.22)

**7.26** Subject to a risk assessment, detainees should have their handcuffs removed as soon as possible. (4.26)

**7.27** Recorded cell checks should take place daily across the custody suites. (4.31)

**7.28** The cell call bell should be explained to detainees when they are located in a cell. (4.32)

**7.29** Emergency practice evacuations should be recorded and a copy kept in the custody suites. (4.33)

**7.30** Subject to an individual risk assessment, a small supply of toilet paper should be routinely placed in each cell. (4.41)

**7.31** All detainees held overnight, or detainees who require it, should be offered a shower, which they can take in private. (4.42)

**7.32** There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy skills. (4.43)

## Individual rights

**7.33** British Transport Police should ensure that there are no unnecessary delays in progressing detainees` cases because of the investigation protocols. (5.13)

**7.34** Custody staff should be made aware of the guide on the role and responsibilities of family or friends acting as an appropriate adult. (5.14)

**7.35** Double-handset telephones should be provided in all suites to facilitate telephone interpretation. (5.15)

**7.36** Detainees should be offered a written notice of the up-to-date version of their rights and entitlements. (5.16)

**7.37** Posters concerning detainees' right to free legal advice should be prominently displayed in a range of languages in all custody suites. (5.24)

**7.38** Detainees should be able to have a private telephone consultation with their legal adviser. (5.25)

**7.39** Sufficient up-to-date copies of the PACE codes of practice should be made available at all custody suites. (5.26)

**7.40** PACE reviews should be carried out on time. (5.27)

## Health care

**7.41** Emergency buzzers in the treatment rooms should be located to ensure staff safety and chairs should be movable. (6.10)

**7.42** Alcohol and opiate withdrawal screening tools should be available in all suites. (6.24)

# Section 8. Appendices

## Appendix I: Inspection team

| | |
|---|---|
| Elizabeth Tysoe | HMIP team leader |
| Gary Boughen | HMIP inspector |
| Vinnett Pearcy | HMIP inspector |
| Fiona Shearlaw | HMIP inspector |
| Mark Ewan | HMIC lead staff officer |
| Paul Davies | HMIC staff officer |
| Nicola Rabjohns | HMIP health services inspector |
| Laura Nettleingham | HMIP researcher |