



Report on an unannounced inspection visit to police
custody suites in

Metropolitan Police Service North and North East clusters

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary and Fire & Rescue
Services

19–30 June 2017



This inspection was carried out in partnership with the Care Quality Commission.

Glossary of terms

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Contents

Section 1. Introduction	5
Section 2. Background and key findings	7
Section 3. Leadership, accountability and partnerships	15
Section 4. Pre-custody: first point of contact	19
Section 5. In the custody suite: booking in, individual needs and legal rights	21
Section 6. In the custody cell, safeguarding and health care	29
Section 7. Release and transfer from custody	41
Section 8. Summary of areas of concern, recommendations and areas for improvement	43
Section 9. Appendices	47
Appendix I: Inspection team	47

Section 1. Introduction

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

This was the first inspection of police custody suites in the Metropolitan Police Service (MPS) North and North East cluster that we have carried out, covering nine boroughs previously reported on. Given the varying 'starting points' in each borough, and because the scale and nature of the new arrangements were so different, it was not possible to make a comment overall on progress since the previous inspections, and we have not followed up the recommendations from the previous reports.

We found many positive features during this inspection. Principally, detainees were usually treated well and the conditions they were held in were generally good. It was encouraging that the MPS went to some lengths to minimise the risks presented by potential ligature points in the custody environment. We also identified several areas of concern, some of which could be dealt with by the MPS itself, and others that could only be addressed in collaboration with partner agencies.

As we commonly find, too many children who were charged and refused bail remained in custody overnight, and sometimes the weekend, when they should have been moved to alternative accommodation provided through the local authority. The MPS was some way behind other forces in developing the necessary strategic links to make progress in this area. The support provided to children and vulnerable adults through the appropriate adult scheme was also particularly weak and needed to be improved.

There were some frailties in the way Police and Criminal Evidence Act 1984 (PACE) reviews were conducted, but these were linked to organisational issues that could be resolved relatively easily. Oversight and monitoring of health provision were not adequate, which meant that detainees with the greatest health needs were not always seen quickly enough. The MPS needed to agree and follow up agreed response times with forensic medical examiners.

Despite the areas highlighted that require attention, overall this was a positive inspection and, given the initial reaction to our findings, we are confident that the MPS has the capacity and commitment to work constructively on the improvements required.

This report provides four recommendations to the force and highlights 31 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

September 2017

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 Inspectorate of Prisons (HMI Prisons) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).¹ 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 Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services 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 College of Policing's *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*² about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.
- 2.3** A documentary analysis of custody records was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.³ The analysis focused on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report these differences are statistically significant.⁴ A total sample of 162 records were analysed.
- 2.4** A data collection template was completed by the force during the inspection and was based on police custody data for the 36 months prior to inspection. The template requested a range of information including data on the demographics of the custody population, the number of voluntary attendees and average length of time in police detention.

¹ This inspection was carried out before 19 July 2017, when HMIC also took on responsibility for fire & rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

² <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

³ 95% confidence interval with a sampling error of 7%.

⁴ A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p < 0.01$ was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

Custody suites	Number of cells
Bethnal Green	19
Forest Gate	15
Fresh Wharf	30
Ilford	17
Leyton	30
Romford	14
Shoreditch	9
Stoke Newington	14
Wood Green	40

Leadership, accountability and partnerships

- 2.5** The Metropolitan Police Service (MPS) had a clear internal governance structure for custody and this provided accountability for the safe delivery of custody. However external links with strategic partners were weak, and there was ineffective scrutiny in several areas
- 2.6** The force had effective internal meeting structures to oversee provision of custody services. However, there was a clear gap in strategic engagement with statutory partners to provide effective scrutiny in a range of areas, including the provision of local authority accommodation for children, and appropriate adult services.
- 2.7** There were generally sufficient custody staff resources to ensure safe detention. However, there was a clear deficiency in the number of designated detention officers (DDO) and an overreliance on overtime for DDOs and sergeants. Comprehensive training was provided for custody staff but, given competing priorities, there was not always sufficient emphasis on safe detention.
- 2.8** Although there were some diversion schemes, the force still lacked a central focus on preventing children and vulnerable people from coming into the criminal justice system. Liaison and diversion pathways, while positive, were limited.
- 2.9** There was a lack of clinical governance, strategic oversight and monitoring of the provision of medical services (see paragraph 2.40).
- 2.10** There was good collation and monitoring of performance data on custody and most areas of performance were well understood, but this was not comprehensive across all key activities. Although adequate data on the use of force in custody suites were collected, scrutiny of this information was insufficient. The force had a very effective adverse incidents process.
- 2.11** The quality of data held on children in custody had improved but the profile was still not complete. There had been only limited progress in preventing the detention of children

overnight, and long-term problems associated with the provision of appropriate adults remained unresolved.

- 2.12** Relevant data on diversity were collated, but it was not apparent how the data were used to inform practice in police custody.
- 2.13** Services for detainees with mental ill health had significantly improved. There had been no instances in the North or North East areas in the past 12 months where a detainee was brought into police custody as a place of safety under section 136 of the Mental Health Act.⁵
- 2.14** We were not confident that partnership work across all areas was effective enough to make the improvements required in police custody.

Pre-custody: first point of contact

- 2.15** Frontline officers showed a good understanding of vulnerability, and it was reassuring that they regarded all children as vulnerable by virtue of their age.
- 2.16** There was limited information to officers responding to incidents to guide their risk assessments and decision making about arrest. Little information was provided by the control centres or the intelligence hubs, and officers had little access to information through mobile technology. Access to multiagency information was very limited.
- 2.17** It was positive that frontline officers did not take people detained under section 136 of the Mental Health Act into custody as a place of safety, although this could mean long waits with detainees before a health-based place of safety became available.
- 2.18** Frontline officers were also aware of the importance of avoiding taking children into custody and used alternatives such as community resolutions⁶ when possible. However, the seriousness of some offences and the lack of diversion schemes limited the opportunities to divert children from the criminal justice system.

In the custody suite: booking in, individual needs and legal rights

- 2.19** Custody staff treated detainees with respect and courtesy, and this was particularly evident during the booking-in process. Because of the way suites were designed, it was often difficult to maintain privacy when detainees were interviewed.
- 2.20** In general, the force paid reasonable attention to meeting the needs of detainees from minority groups, although the arrangements for dealing with female detainees were inadequate. There were adequate facilities available to provide interpreting for non-English speakers, but touchscreen translation kiosks were underused.

⁵ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

⁶ The resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

- 2.21** The quality of risk assessments was good but there were some weaknesses in carrying out observations, particularly during busy periods.
- 2.22** Most staff handovers were properly focused on detainee welfare and the identification of risks, but some were too brief and did not include all the relevant information about detainees. They did not always take place in sufficient privacy or with the attendance of all relevant staff.
- 2.23** The majority of custody sergeants could provide us with examples of when they had refused detention. We saw that detention was appropriately authorised, but the correct time of the detainee's arrival was not always recorded, and we were not confident that the figures for waiting times that we saw were accurate. Voluntary attendance⁷ was used actively as an alternative to custody, but interviews usually took place in custody suites, which was contrary to the purpose of this alternative.
- 2.24** Although some cases were progressed promptly, there were sometimes lengthy delays due to the non-availability of investigating officers, forensic medical examiners (FMEs) or appropriate adults.
- 2.25** Home Office Immigration Enforcement officers were based in some custody suites, and staff reported that this relationship worked well, resulting in foreign national detainees being served with authority to detain notifications (IS91) and moved on promptly, although there were occasional delays.
- 2.26** We found out-of-date rights and entitlements notices for detainees in some suites, and not all custody staff offered detainees a copy of their rights, or knew that this material was available in an easy-read format. There were no current versions of PACE code C in any of the suites.
- 2.27** Reviews of detention were often conducted to suit the needs of inspectors rather than for the benefit of the detainee. Some were carried out too early, and when detainees were asleep or in interview there was often no record that they were given an explanation or offered their rights. Detainees being reviewed were routinely interviewed through the cell hatch door, which inhibited good communication.
- 2.28** The force had prepared for the changes to pre-charge bail that had been brought in under the Police and Crime Act 2017 in April 2017. Custody staff in particular were well briefed and many had been trained in the changes in procedure. Since the act had become law, there had been a considerable reduction in the number of detainees bailed and many were now 'released under investigation' instead, without any obligation to return to police stations.
- 2.29** The force had created some processes to check if investigations were progressing 'expeditiously and diligently', but these had not yet identified the causes of delays in many investigations.
- 2.30** There was no visible publicity about the complaints process in any of the custody suites. Custody staff were confident in how to manage complaints received in custody.

⁷ Where individuals attend a police station by appointment to be interviewed, avoiding the need for arrest and subsequent detention.

In the custody cell, safeguarding and health care

- 2.31** Conditions in the suites were generally good, although repairs were not completed quickly enough. We inspected the suites during very hot weather when many of the cells were uncomfortably warm.
- 2.32** Staff were reasonably aware of the fire evacuation procedures, although not all suites displayed them prominently. We found sufficient sets of handcuffs for detainees in case of emergency evacuation. Not all suites had regular fire evacuation drills.
- 2.33** Most staff dealt patiently and calmly with detainees and employed good skills to de-escalate many challenging situations. Sergeants did not routinely carry safety equipment in the controlled custody environment, and there had been no recorded use of Tasers or batons in the suites.
- 2.34** A third of the cases involving use of force that we examined were managed well, but we found learning points in half of the cases we looked at. Handcuffs were used frequently on detainees brought into custody but were not always removed quickly enough when they were compliant. The level of strip searching was slightly higher than we usually find, although the rationale for strip searches was appropriate.
- 2.35** Adequate food and drinks were provided for detainees, although there should have been more active effort to provide water during our inspection when the weather was very hot. Although staff could provide detainees with access to books, exercise and showers, they relied on detainees requesting them rather than actively offering them. Exercise facilities for detainees were generally poor. All suites had good supplies of replacement clothing and shoes for detainees, although replacement underwear was not available.
- 2.36** Custody staff had variable knowledge of safeguarding issues and had little direct involvement in making safeguarding referrals for children and vulnerable adults, which was done by arresting and investigating officers. They generally saw their role as limited to detainee care and well-being during custody and on release.
- 2.37** There was some good care for children in custody, but girls were not allocated to a female officer and we were concerned that staff were unaware of this requirement.
- 2.38** Provision of appropriate adults (AA) for children and vulnerable adults was inadequate. Detainees often had to wait too long for support, and the administrative arrangements for organising this provision were not efficient.
- 2.39** The force was now closely monitoring the circumstances surrounding detained children. Relevant data were scrutinised internally and shared with external partners in an attempt to improve outcomes for children. Despite this, our analysis showed that some children still spent too long in custody.
- 2.40** The force directly managed and provided its own primary health services in police custody, but there was a lack of clear performance measures to ensure detainees' health needs were met. Some aspects of clinical governance were good but overall many areas, including audits and supervision arrangements, were underdeveloped, primarily due to inadequate resources and systems. There were no agreed response times linked to clinical and forensic priorities and calls went directly to individual practitioners, with the risk that detainees with the greatest need would not be seen promptly.
- 2.41** The clinical environment in all suites had been refurbished and was mostly good, but cleanliness in many clinical rooms was inadequate. Clinical record keeping did not

consistently meet the required professional standards and information governance requirements. Custody staff were trained to use and had easy access to well-checked emergency equipment, which was good.

- 2.42** Custody staff reported, and we observed, good partnership working with health care professionals. Response times in the busiest suites had improved as health care professionals were being based there, but responses in the areas covered by FMEs regularly took too long. However, the individual patient care we observed was good, although patient confidentiality was compromised as doors were routinely left open during consultations.
- 2.43** Detainees had appropriate access to most required medication, including symptomatic relief for substance withdrawals in custody. Governance of medicines management was underdeveloped and access to community-prescribed opiate substitution treatment was too inconsistent. Nicotine replacement treatment was not available in any suite, which could exacerbate the distress of detainees who smoked.
- 2.44** All suites provided target drug testing and referral to mandatory treatment, and this was effectively monitored by a central force team. Most suites also had substance misuse workers who offered support to adults with alcohol and/or drug issues, with impressive embedded services at Bethnal Green and Wood Green.
- 2.45** A weekday mental health liaison and diversion service provided positive support for detainees, and supported effective risk management by custody staff in all suites. High demand and staffing issues in some suites meant that detainees were often prioritised according to clinical need. Most detainees who required an assessment under the Mental Health Act were seen within three hours and transferred promptly, although there could be long delays due to the lack of specialist assessment staff, beds and ambulances. The force had good systems to escalate and investigate these incidents in partnership with NHS services and commissioners. No individual had been detained in any of the suites we inspected as a place of safety under section 136 in 2017, which was part of an impressive London-wide strategy.

Release and transfer from custody

- 2.46** Sergeants spoke to all detainees before their release and took action to reduce risk and identify any welfare concerns. However, this was not always reflected in the pre-release documentation, which often lacked detail.
- 2.47** Most detainees were given up-to-date information leaflets with details of support organisations before their release, although not all staff were aware that these were available in nine languages. The pilot referral scheme at two sites to support 16-30 year olds was a promising initiative.
- 2.48** Travel warrants were not available in most suites and staff could not access petty cash to support detainees in need. Detainees were routinely asked how they would get home after release, and officers facilitated telephone calls to arrange travel. Transport home for children was arranged routinely.
- 2.49** We were told that most detainees would be seen up to 3pm at one of the four courts serving the clusters, if they were at the court between 2pm and 3pm, so remanded detainees did not usually stay in custody for longer than necessary. There were no significant blockages except at Romford, which reported a less favourable service.

- 2.50** There was a clear process to guide custody staff completing person escort records (PERs). Those we reviewed were of mixed quality, with some variation in the level of detail or procedural practice. Too many PERs included loose leaf risk assessments and confidential medical records insecurely attached, which was poor practice.

Areas of concern and recommendations

- 2.51** **Area of concern:** Too many children charged and refused bail remained in custody overnight, and sometimes the weekend, when they should have been moved to alternative accommodation provided through the local authority.

Recommendation: The force should agree arrangements with local authority partners to avoid the overnight detention of children in custody by their transfer to suitable alternative accommodation. These arrangements should include procedures to escalate cases, with strategic monitoring and oversight by the force and with partners on local safeguarding children's boards.

- 2.52** **Area of concern:** The arrangements for obtaining appropriate adults did not ensure that all children and vulnerable adults received early and effective support.

Recommendation: The force should ensure that appropriate adult (AA) services are prompt and effective, and work with local authority partners to deliver consistent outcomes for detainees. There should be early support to detainees, with access to 24-hour services when needed. Records of AA request and arrival times and their status should be recorded accurately on custody records, with the information used to assess outcomes for detainees.

- 2.53** **Area of concern:** Inspectors did not conduct PACE reviews adequately for the purpose of detainees' detention and welfare, but instead for their own convenience.

Recommendation: The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984.

- 2.54** **Area of concern:** The lack of agreed response times by forensic medical examiners (FMEs), linked to clinical and forensic priorities, meant that some detainees with the greatest health need were not always seen promptly, creating a significant risk of poor health outcomes. The lack of clear performance targets and outcome measures, and underdeveloped clinical governance, resulted in inadequate oversight and monitoring of health provision.

Recommendation: Detainees should be seen by forensic medical examiners (FMEs) within agreed response times that are linked to clinical and forensic priorities. There should be robust clinical governance, including performance targets, outcome measures and clinical audits, to ensure the health needs of detainees are consistently met.

Section 3. Leadership, accountability and partnerships

Expected outcomes:

There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

- 3.1 The Metropolitan Police Service (MPS) had a clear governance structure for custody. A dedicated detention command provided central support and oversight across the force and had overall responsibility for the custody function. This was supported by specialist staff trained to deliver custody services. This structure provided clear accountability for the safe delivery of custody.
- 3.2 The force had effective internal meetings to oversee custody provision and provide appropriate governance. However, there was limited strategic engagement with external partners for effective scrutiny of key areas of custody, in particular to ensure that local authorities met their statutory responsibilities to provide accommodation for children, and for appropriate adult services.
- 3.3 The force had adopted the College of Policing's *Authorised Professional Practice - Detention and Custody*. This was enhanced by a custody policy 'toolkit', which provided clear guidance to staff in areas of custody service provision. In practice, not all staff had a good understanding of force policies and procedures, and the force needed to ensure that staff were consistent in following these.
- 3.4 There were generally sufficient custody staff resources to ensure safe detention. However, there was a shortage of designated detention officers (DDOs), with only 598 at the time of the inspection against the force-wide establishment figure of 730. This affected the force's commitment to ensure that only trained staff were responsible for the care of detainees, and the force needed to address the high staff turnover of DDOs progressing to become police officer to minimise the impact on detainee care.
- 3.5 The force provided comprehensive training for custody officers and DDOs before they took up their duties, as well as four mandatory professional training days annually. The high demand on these training days led to a focus on operational and investigative training rather than the professional development of safe detention for staff.
- 3.6 There was no central focus on preventing children and vulnerable persons coming into the criminal justice system and their diversion away from custody. While there were some diversion schemes to minimise and reduce reoffending, these varied across the areas, and liaison and diversion pathways were generally limited. (See recommendation 2.51.)
- 3.7 A lack of clinical governance, strategic oversight and monitoring of the medical services hindered their effective delivery to detainees (see paragraph 6.45 and recommendation 2.54).

Areas for improvement

- 3.8** The force should ensure that all staff are aware of and adhere to the force custody toolkit.
- 3.9** The force should have sufficient staff in all roles to ensure the safe delivery of custody.

Accountability

- 3.10** The collation and monitoring of performance data on custody were good and most areas of performance were well understood. However, this was not comprehensive across all key activities, and was in some areas inaccurate. For example, the data on overall detention times did not include waiting times of more than four hours, and our case audits and observations showed instances where the recording of the detainee's time of arrival at police stations was clearly incorrect.
- 3.11** The force was not complying with all areas of the Police and Criminal Evidence Act (PACE) code C covering the detention, treatment and questioning of suspects (see paragraphs 5.27, 5.30, 5.40 and 6.32 and recommendation 2.53).
- 3.12** The force collated records of use of force incidents in its custody suites, and was able to provide the data required for the Home Office annual data return, as recommended by the National Police Chiefs Council (NPCC). The force also monitored incidents and cross-referenced these to CCTV to provide governance and assurance to itself, the Mayor's Office for Policing and Crime and the public that the use of force in detention and custody was safe and proportionate. However, our examination of CCTV footage identified some concerns about the use of force, and we were not confident that the force's scrutiny of such incidents was sufficiently robust to identify potential problems.
- 3.13** There was a very effective process for reporting adverse incidents, which were all recorded as successful interventions and reported to the force strategic health and safety board. Learning from adverse incidents and near misses was shared, and used to improve organisational learning and inform training.
- 3.14** Although the force collated specific diversity data for custody, it was unclear how this was used to inform strategic learning or service improvement. There were no specific action plans or monitoring arrangements covering custody, and it was not clear how the force could demonstrate that it was meeting the public sector equality duty in relation to custody.

Partnerships

- 3.15** The arrangements to deliver effective joint working in some key areas of custody were underdeveloped. The organisational arrangements were such that some areas of business affecting custody did not sit directly within the central detention command. This limited their direct involvement and it was not clear how they influenced custody priorities around partnership working. In particular, little progress had been made regarding the provision of alternative accommodation for children, and there was no secure accommodation available across London. While the quality of data had improved and this made it easier to understand the scale and nature of the problem, nearly all children charged and refused bail continued to remain in custody overnight.

- 3.16** The force had made little progress in partnership work to improve the provision of appropriate adult services, and had failed to address the weaknesses identified in previous inspections. As a result, detained children and vulnerable adults did not receive timely and effective support (see recommendation 2.52).
- 3.17** Positively, the force had made significant improvements in provision for detainees with mental ill health. There had been no instances in the North or North East areas in the previous 12 months of detainees brought into police custody as a place of safety under section 136 of the Mental Health Act.⁸ Although this area of responsibility was not directly under the custody directorate command, effective representation of the custody command team at governance meetings had clearly led to significant improvement.

⁸ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

Section 4. Pre-custody: first point of contact

Expected outcomes:

Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

Assessment at first point of contact

- 4.1** Frontline officers demonstrated a good understanding of detainee vulnerability. Although they were not aware of any force definition of vulnerability, they assessed each potential case, taking account of factors such as mental ill health and the individual's circumstances. They used a vulnerability assessment framework to identify where a person had additional needs and could need extra help or protection. All children were regarded as vulnerable by virtue of their age.
- 4.2** Training to support frontline officers in identifying and dealing with vulnerable people was limited, apart from in some officer safety training and continual professional development (CPD) days and on some e-learning topics. There were few opportunities for officers to attend training courses, and none could not recall any training on the Mental Capacity Act 2005 to help them identify people who could be incapable of making their own decisions. In general officers relied on their own experiences in dealing with vulnerable people and deciding the action they needed to take, which risked an inconsistent approach.
- 4.3** Frontline officers were not given sufficient and timely information when they responded to incidents. They did not always receive intelligence available on police systems from the control centres and intelligence units, and had limited mobile technology to access this information themselves. Officers often relied on information across the radio system from colleagues who knew the suspect, victims or the local area where the incident was taking place. They also had little access to information on individuals held by partner agencies, especially outside normal working hours. This meant that frontline officers often had to assess risks and decide whether to arrest an individual or consider other alternatives without the necessary good quality intelligence. They told us that they might have dealt with some incidents differently had they had more information at the time.
- 4.4** Positively, frontline officers did not take people detained under section 136 of the Mental Health Act 1983 into custody as a place of safety.⁹ Although this meant that they were sometimes long waits with detainees while a health-based place of safety became available, this was a better and more appropriate outcome for these detainees. However, some people with mental ill health were arrested and taken into custody when alternatives might have been more appropriate, had there been support from partner agencies. Decisions about mental capacity were often made with advice from the London Ambulance Service, and there was some support from mental health partners in incidents involving people with mental ill health. However, this was not consistent and the arrangements varied between areas. Frontline officers told us that they felt unsupported and that they often had no alternative

⁹ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

but to arrest the individual for the offence committed, leaving any mental health support or assessments to be arranged once they were in custody.

- 4.5** Frontline officers were focused on avoiding taking vulnerable people, and especially children, into custody. Where possible and appropriate, they considered alternatives, such as voluntary attendance,¹⁰ fixed penalty notices, community resolution¹¹ or civil means for resolving the incident in liaison with the victim. However, for children in particular, the seriousness of many of the offences, often involving violence and weapons, and the lack of diversion schemes for less serious offences limited the opportunities to divert children away from custody.
- 4.6** Detainees were generally transported to custody in police vans. Officers reported that there could be delays when vans were not readily available, and sometimes used their police cars to take an individual to custody, based on a risk assessment. There were also some long waits for ambulances to transport detainees to hospital. Frontline officers had discretion to use their own cars if the risk assessment indicated it was safe and in the best interests of the detainee.
- 4.7** The decision to handcuff an individual on arrest or during transport was based on a risk assessment. Frontline officers generally said they would normally handcuff detainees and that it was their decision when to remove these, based on the risks. We observed that detainees sometimes remained handcuffed a long time because of delays in transport or waits to be booked in in the custody suite, which did not always seem to be justified. Although the use of force and any use of handcuffs was recorded in the custody record, there was no consistent completion of the use of force forms when handcuffs were used, as required under force policy.
- 4.8** Frontline officers understood the importance of relaying any additional information about detainees to custody sergeants to inform the risk assessment and their care while in custody. However, the lack of any system or formal questions when booking in meant this did not always happen.

Area for improvement

- 4.9 Frontline officers should have sufficient and timely information from police intelligence systems to underpin their risk assessments and inform their decision making when dealing with incidents.**

¹⁰ Where individuals attend a police station by appointment to be interviewed, avoiding the need for arrest and subsequent detention.

¹¹ The resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

Section 5. In the custody suite: booking in, individual needs and legal rights

Expected outcomes:

Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

- 5.1** Custody staff generally treated detainees courteously. The interactions that we observed, particularly by custody sergeants when booking people in and out of custody, reflected an engaging and personable approach, with staff seeking to build a rapport with detainees while remaining professional. This approach helped staff to deal with some challenging individuals in a constructive way. Detainees arriving into custody were consistently asked to define their ethnicity, rather than rely on assumptions by staff, and were given explanations if they were unsure what this meant, which was positive.
- 5.2** We found some lack of privacy for detainees in the suites. In-cell CCTV monitors at Forest Gate and Leyton were visible to other detainees in the main area, which was inappropriate. Privacy in booking-in areas was generally poor, even where privacy screens were installed between desks, and detainees could often see and hear one another – made worse at some suites (such as Romford, Forest Gate and Stoke Newington) by the lack of space between the desks. Other factors, such as noise from staff conversations, telephones and radio, also hindered private communication. These problems were further compounded by the lack of desks sited away from the main area. Although such facilities were available at Leyton and Wood Green, staff indicated that they were not used routinely for all appropriate situations, such as dealing with children, vulnerable adults or those with hearing impairments.
- 5.3** All detainees being booked into custody were asked if their detention affected anyone else, so custody staff were aware of those with care responsibilities so that appropriate measures could be taken. We saw this in practice at Leyton, when a female detainee told staff she had a young child being looked after at home who required breastfeeding. Following discussions between custody staff, the detainee and the investigating officer, the child's carers were contacted to arrange the child's feeding at the detainee's expected return. Women coming into custody were also usually asked if they wished to speak to a female officer, but this was not always specified as being available in private (to which they were entitled) and female staff were not always on duty to make this immediately possible. Women were also asked if they were pregnant, but not if they required sanitary items, which were available at all suites. Although the custody NSPIS (national strategy for police information systems) IT system generated a reminder to staff about this when allocating a female detainee to a cell, there was no requirement to complete this. Some staff accepted that this did not always happen and they relied on the detainee to request sanitary products if they needed them, which was inappropriate.
- 5.4** Arrangements for identifying and meeting other diverse needs were inconsistent. Detainees were routinely asked about their dietary or religious requirements, and all meals were halal-suitable. Most suites stocked a generally adequate selection of religious artefacts, including texts, prayer mats and/or compasses, with notably good provision at Romford and Bethnal Green. However, these were not always stored in a suitably respectful way, including

Qur'ans not being kept above waist height or items kept untidily. There was also no guidance to staff on religious worship, either locally or online, and although some staff said local area experts were available for advice, not all boroughs knew about this. Ramadan ended during the course of the inspection. Custody staff were sensitive to the needs of Muslim detainees who were affected by this and made sure relevant information was shared. There was also evidence that staff routinely ensured that detainees observing Ramadan received their meals outside their fasting period. However, staff admitted that it was not always possible to arrange for detainees to pray outside their cell or use other washing facilities if their cells did not have a sink, although we did observe this happening at Wood Green.

- 5.5** The force's custody policy set out some impressive arrangements for the provision of fresh Kosher food for Jewish detainees, but not all custody staff knew about or used these. Staff were inconsistent in their accounts about arrangements for detainees on special diets. Some said that such detainees could arrange to have (sealed) food brought in, subject to a risk assessment, although this was inconsistent between and even within suites. Staff did not often buy special food for detainees when required. There were some limited options for vegetarian and vegan detainees, and detailed guidance usually available about whether a meal was suitable for those with an allergy or intolerance (such as gluten).
- 5.6** Hearing loops were not always available to assist detainees with hearing impairments, and where they were (such as at Romford, Ilford and Fresh Wharf), staff had little confidence or knowledge of how to use them. There was also a lack of materials available in Braille for blind and visually impaired detainees, such as rights and entitlements documents.
- 5.7** Arrangements for detainees with restricted mobility were generally poor. Force custody policy permitted some exceptional arrangements, such as allowing guide dogs or 'familiar personal assistants' to remain with physically disabled detainees in custody (where staff were assured of the risks); this policy was highly unusual and impressive. However, facilities in most suites were not suitable with few adaptations or equipment for detainees with disabilities. We found no wheelchairs or other mobility support aids at any of the suites, although staff told us they might allow detainees with their own equipment to retain them in their cell. There were no extra thick support mattresses for detainees who were elderly or had disabilities, although staff said they would use multiple standard mattresses if necessary where supplies allowed. A few cells at Wood Green and Leyton had lower-height cell call bells to help detainees with restricted movement, but these were not backed up by appropriately adjusted intercom panels to facilitate communication, or other adapted facilities, such as step-free, rail-supported toilets or shower rooms. The force's custody policy and staff were not clear about which suites in the cluster were designated as suitable for detainees with physical needs, and we were not assured that such detainees would be taken to the most suitable facility available.
- 5.8** There was limited staff training to support them in dealing with people with diverse needs. Although staff said they had received initial training on vulnerability (such as mental health), in most cases this had been a considerable time ago. Refresher training on related topics was described as piecemeal at best. Staff were expected to receive one day's personal development training every three months, mostly covering changes to custody policy and procedure alongside some guidance on themes such as child sexual exploitation. However, this had not been reinforced by relevant e-learning or classroom inputs, and staff could not recall any relevant training to develop their knowledge of the range of detainees' individual needs.

Communication

- 5.9** Professional telephone interpreting services were available to assist staff dealing with non-English speaking detainees via two-way handsets, which, with the exception of Forest Gate, were said to work well. ‘Virtual’ interpreters based at a central force building for use across the entire force area were available to assist with detainees’ interviews, with their consent. We were told that this practice was effective and eliminated delays in waiting for interpreters to arrive at the suite. However, staff said that a good face-to-face interpreter service was also available throughout the cluster.
- 5.10** All custody suites had touchscreen language terminals in the booking-in area for basic translation, particularly during the booking-in process. However, although the screens displayed questions in the required language, there were no English subtitles to inform custody staff of what the detainee was being asked, and we were told that the range of ‘scripts’ was too limited. As a result, custody staff considered these terminals to be unhelpful and made little use of them.

Risk assessments

- 5.11** During the inspection, we saw over 50 detainees being booked in, mostly without delay. The majority were booked in by custody sergeants, with the support of designated detention officers (DDOs) during busy periods. The oversight by sergeants during this process was generally sufficient. Custody staff identified potential risks to detainees effectively, and treated them with patience and sensitivity while completing the standard risk assessment. The comprehensive risk assessment template included a range of questions that were relevant and appropriate. Sergeants took sufficient time to consider the needs of particularly vulnerable detainees and those in custody for the first time, and asked supplementary questions where necessary to obtain more detailed information. There was routine cross-referencing to the police national computer (PNC) warning markers and historical information on the custody record system to inform risk assessments further.
- 5.12** Care plans were put in place for all detainees, and demonstrated an overall awareness of the need to focus on detainee welfare and safety during detention. Detainee observation levels were generally set appropriately and in consultation with the custody sergeant, and staff were confident in adjusting the levels when necessary to support detainees throughout their time in detention. The systems to monitor detainee observations varied across the cluster and in some suites lacked rigour. In the larger suites, DDOs were specifically allocated observations of detainees for whom they had sole responsibility during their shift, while in most of the smaller suites DDOs shared this daily task. In the suites where an individual DDO was not responsible for detainee observations, during busy periods we saw some cell visits taking place later than scheduled. Some DDOs monitored detainees through the cell door observation panel, which limited their ability to assess risk effectively.
- 5.13** Although some staff were knowledgeable about how to manage the risk of self-harm, there were inconsistencies in the care of detainees in crisis. The custody records and our observations showed some good interactions between staff and detainees on constant observations. One detainee with significant mental health problems, including claustrophobia, had his cell door left open, and staff engaged positively with him despite his challenging behaviour. However, we also saw a vulnerable female detainee held in an observation cell with the door closed and handcuffs still applied, which was disproportionate to her risk; the handcuffs should have been removed before she was locked up.
- 5.14** Staff were aware of the importance of monitoring and rousing detainees, particularly those under the influence of drugs or alcohol. There were posters on most cell doors and cell

block corridors promoting the practice and importance of rousing. All staff had been issued with anti-ligature knives, and carried them routinely when working in the suites, which was positive.

- 5.15** The allocation of cell keys was not always managed well enough. During busy periods in some suites, cell keys were not returned promptly or stored securely at the booking-in desk. There was insufficient oversight of the access to cell keys for non-custody staff, including arresting and investigating officers, and some suites sometimes did not enough cells keys during busy periods.
- 5.16** The quality of staff shift handovers was variable and they did not always include all relevant staff. Those we observed usually took place between sergeants, with a separate handover later between DDOs; this resulted in inconsistencies in how information was shared. Handovers usually focused properly on detainee welfare and case progression, but too many took place with insufficient privacy. Sergeants attempted to ensure that booking-in areas were quiet and free of detainees and non-custody staff during handovers, but confidential information about cases was not always discussed in private. At the start of a new shift, we observed sergeants routinely visiting all detainees in their care. During busy periods, sergeants did not always have sufficient oversight of the handovers between staff responsible for the supervision of detainees on constant watch.
- 5.17** There was no use of anti-rip clothing anywhere across the force area, which was commendable. In line with force policy, staff understood that leaving a detainee in their own clothes helped to minimise risk. Laces and cords were not routinely removed from detainees clothing, which was also very positive. Custody staff used the risk assessment and their own observations of the detainee to determine which items of clothing to remove, if any, which was a positive approach.

Areas for improvement

- 5.18** **There should be a consistent and robust force-wide system to monitor detainee observations so that visits to cells are on time and risk is managed effectively.**
- 5.19** **There should be a protocol to manage the allocation of cell keys.**
- 5.20** **Shift handovers should include all relevant staff and take place in sufficient privacy.**

Individual legal rights

- 5.21** Custody sergeants and DDOs under supervision, mainly at the larger suites, booked detainees into custody. In most cases, arresting officers provided a full explanation of the circumstances of, and the reasons for, arrest before detention was authorised. Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and they gave us details of such cases.

- 5.22** Custody staff told us that voluntary attendance (known locally as ‘caution +3’), fixed penalty notices and community resolution¹² were sometimes used as an alternative to custody. Custody staff were unclear about how often voluntary attendance was used as they had no involvement in the process, other than that most interviews took place in facilities inside the custody suites. Most of these facilities could only be accessed through the booking-in areas, which was contrary to the aim of diverting individuals from custody. Force data for the cluster boroughs showed that the use of voluntary attendance had increased by 45% since 2015, up from 4,438 voluntary attendees in the year ending 31 May 2015 to 6,434 in the year ending 31 May 2017, which was an improving picture.
- 5.23** Most detainees we saw were booked in promptly on arrival at the custody suites, but in the custody records we analysed we found some delays of up to two hours 51 minutes. In our observations at Leyton, we saw up to six detainees waiting between one and just under three hours to be booked in. Frontline officers in our focus groups said they regularly experienced long waits, sometimes up to four hours, for their detainees to be booked into custody. Such delays were unacceptable, particularly when they involved vulnerable and compliant detainees who might remain in handcuffs throughout this period (see also paragraphs 5.13 and 6.14 and area for improvement 6.18).
- 5.24** We observed that custody sergeants and DDOs did not always ask arresting officers for their time of arrival at the suites. In one case where we noted a detainee had waited for just over two hours to be booked in, staff recorded the booking-in rather than the arrival time until we intervened. In some other cases, the arresting officers did not always provide the correct time of arrival when requested. These gaps in the custody records had implications for their accuracy. Force data showed average waiting times to be booked in across the two clusters as 19 minutes 54 seconds; given the practices that we observed, we were not confident that these figures were accurate.
- 5.25** Custody sergeants we spoke to were aware of the need to minimise detainee time in detention and to progress cases quickly. We were told and observed that investigations were not always progressed due to several factors, such as the non-availability of investigating officers, appropriate adults (see paragraph 6.33 and recommendation 2.52) and forensic medical examiners (FMEs) (see paragraph 6.48 and recommendation 2.54), which lengthened detainee stay in police custody. At several suites, we observed detainees who were held in custody for almost 23 hours, which was unacceptable as they could have been interviewed much earlier if the resources had been available. Custody staff told us that this happened regularly. In our custody record analysis, the average detention was 15 hours 21 minutes, which was significantly higher than the figure of 12 hours 50 minutes for forces we have inspected since March 2016.
- 5.26** Home Office Immigration Enforcement staff were based full time in four of the custody suites, which had led to a streamlining in dealing with immigration detainees across the clusters. The staff worked dayshifts with weekend cover from local immigration offices. Custody and immigration staff reported good working relations and saw their joint work as a positive initiative. We were told that most immigration detainees who were to be transferred to immigration removal centres (IRCs) were usually moved on within 24 hours, although there were sometimes longer delays. We observed several immigration detainees being transferred to IRCs who had been held between four hours 40 mins and 24 hours

¹² Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about alleged offences, avoiding the need for an arrest and subsequent detention. Community resolution for a less serious offence or antisocial behaviour incident involves informal agreement between the parties rather than progression of an offender through the criminal justice process.

following service of an IS91 warrant of detention.¹³ Force data showed that 2,147 immigration detainees had been held in the year to 31 May 2017, which was a 13% increase on the 1,898 held in the year to 31 May 2015. Force data for the cluster boroughs also showed that the average length of detention for immigration detainees between service of an IS91 and transfer to an IRC for the year to 31 May 2017 was 13 hrs 41 minutes, which was not unduly long.

- 5.27** During booking-in, custody sergeants and DDOs advised detainees of their three main rights - to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the Police and Criminal Evidence Act (PACE) codes of practice. Although there was a written notice setting out a detainee's rights and entitlements, which the force had updated in May 2017, not all custody staff routinely offered this to detainees, which was contrary to PACE code C,¹⁴ and we found some out-of-date versions in two suites. These notices were available in a range of foreign languages for non-English speaking detainees, which in most cases we saw were appropriately issued.
- 5.28** Although the rights and entitlements information was available in an easy-read format to assist detainees needing help with understanding or reading, very few custody staff were aware of or able to find this document. We saw one detainee who disclosed that she had difficulty with reading being issued a standard written notice of rights and entitlements, with no consideration about how she would decipher it. The information was also not available in Braille in any of the suites.
- 5.29** We saw detainees being told that they could inform someone of their arrest, which staff facilitated, and they usually allowed the detainee to speak to their nominated representative while still at the booking-in desk.
- 5.30** All detainees were offered free legal representation and were told that if they declined, they could change their mind at any time and accept this offer. Those wishing to speak to legal advisers on the telephone could not do so in private in some of the custody suites as all telephone calls had to be taken at the custody suite booking-in desks, which was inappropriate and contrary to PACE code C. (See recommendation 2.53.) There were sufficient consultation and interview rooms at all the suites, and legal advisers were given a printout of their client's front sheet custody record on request.
- 5.31** Detainees were told during their booking in that they could read the PACE codes of practice, but these were not always adequately explained or actively offered to detainees. We found insufficient copies of PACE code C in the suites, and these had not been updated to the current version (23 February 2017).
- 5.32** Most custody sergeants were not aware that documents such as authorisation of detention and charge details were available in a range of languages on the force website. Some of the few who were aware of these documents could not locate them, but printed versions were available in two of the suites. Posters in foreign languages informing detainees of their right to free legal advice were displayed in all the custody suites.

¹³ Served on an immigration detainee when there is no reasonable alternative course of action, e.g. if there is a likelihood they may abscond; their removal from the UK is imminent, etc.

¹⁴ Police and Criminal Evidence Act 1984 (PACE) Code C is the code of practice for the detention, treatment and questioning of persons by police officer.

- 5.33** There was an effective system for weekly collection of DNA samples taken in custody, but we found a significant number of old DNA samples and evidential samples in fridges and freezers at Wood Green. There had been attempts to clear these backlogs without success. We also found some perishable items in the freezers at several custody suites, which was inappropriate.

Areas for improvement

- 5.34** **The Metropolitan Police Service should monitor the average waiting times for detainees from their time of arrival into custody to authorisation of their detention to ensure that detainees are booked in promptly on arrival.**
- 5.35** **Custody sergeants and designated detention officers should ensure that the detainee's correct time of arrival is recorded accurately on custody records.**
- 5.36** **The Metropolitan Police Service should monitor detention times to ensure that detainees are dealt with quickly and are released as soon as the need for detention no longer applies.**
- 5.37** **DNA and other evidential samples should be submitted in good time, and refrigerators and freezers for samples in the custody suites should store only appropriate items.**

PACE reviews

- 5.38** We found that inspectors often carried out six- and 15-hour reviews of detention at their convenience rather than for the benefit of detainees, who should be at the centre of this statutory requirement. Many reviews were perfunctory and had little purpose. In contrast, some inspectors were well prepared and focused on the specific needs of detainees, as well as the requirements of PACE reviews.
- 5.39** Although reviews were generally carried out within the PACE time limits, some took place well beforehand and often when the detainee was sleeping, in interview or otherwise engaged. In these circumstances, 'time reminders' were set for custody officers to explain the results of reviews and offer detainees their rights. However, in most cases, we could find no records that this had been done; this contravened PACE code C, denied detainees their rights and posed an increased risk of harm. (See recommendation 2.53.)
- 5.40** In most cases, inspectors considered the continued grounds for detention and correctly authorised detainees to be further detained. However, we observed one case where the inspector authorised continued detention following the six-hour review despite the lack of any meaningful investigation. In a second case we saw, a vulnerable detainee was 'released under investigation' after 23 continuous hours in custody without any record of 'securing and preserving evidence or obtaining evidence by questioning' (PACE); the inspectors who had conducted the six- and 15-hour reviews had authorised continued detention on the grounds they were satisfied of the progress of the investigation, even though no investigation had been identified as taking place.
- 5.41** The routine practice of reviewing detainees through the small hatch of closed cell doors, even though most detainees did not pose a risk, was a barrier to communication and patronising, particularly for children and vulnerable people who saw only part of the face of the reviewer. There was good practice by some inspectors who checked the detail of detainee risk assessments and other records in preparation for reviews. Reviews by

superintendents following extension of detention applications were considerate and conducted face-to-face with detainees.

Access to swift justice

- 5.42** The force had an extensive structured plan to introduce the Police and Crime Act 2017 changes to pre-charge bail, which included briefing a large part of the workforce and criminal justice partners. Custody staff were particularly well briefed and many had been trained in readiness for the changes. Despite these efforts, many staff were hesitant to bail people for further investigation, and the force was now promoting the appropriate use of bail.
- 5.43** Since the act became law in April 2017, there had been a considerable reduction in the number of detainees bailed, with many now 'released under investigation' with no obligation to return to police stations.
- 5.44** We found a small but not insignificant number of cases in which suspects had not answered their bail and, at the same time, investigating officers had not attended the custody suite or made contact with custody officers when the suspect was due to answer bail. We found that officers failing in their duty to be available when suspects answered bail did not receive any sanction, and other officers continued immediate enquiries in their absence.
- 5.45** To check if investigations were taking too long, the force had created some processes to identify if they were progressing 'expeditiously and diligently'. However, these did not provide a full understanding of the causes of delays in a significant number of investigations. The force was experiencing problems similar to other forces in the wake of the new legislation.

Complaints

- 5.46** When we asked custody staff how they would deal with a detainee wishing to make a complaint, they were consistent in confirming this would be dealt with by discussion with the detainee or, where more serious issues were raised, passed on to the duty inspector for action. However, no information on the complaints process was displayed in any of the custody suites. There were also no separate processes for complaints relating to police or clinical care matters, resulting in the force dealing with all complaints regardless of their nature.

Section 6. In the custody cell, safeguarding and health care

Expected outcomes:

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent health care practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

- 6.1** Cleanliness in the suites across the clusters was adequate with very little evidence of in-cell graffiti. Communal areas and cells were clean and in good condition, although not all cells had handwashing facilities. We found few potential ligature points in cells, which was positives, and those we identified were dealt with during the in inspection. Exercise yards were generally poor and not available in all suites (see paragraph 6.26).
- 6.2** There were daily suite checks by designated detention officers (DDOs) in the mornings and night shifts using a comprehensive checklist, which included all cells, communal areas and in-cell potential ligature point check. Oversight of these checks was good and custody managers signed off the checklists each day. Most suites were cleaned twice a day, and DDOs cleared cells between use. Arrangements to remove biohazards were adequate.
- 6.3** Although there was an easy-access procedure for staff to report any defects in the suites, repairs were not carried out promptly, which resulted in cell closures. Seven of the 30 cells at Fresh Wharf were out of use due to defects; one had been out of use for four weeks. At Romford, a cell with peeling floor paint had been out of use for six weeks, and at Forest Gate a cell with a faulty observation pane had been out of use for seven days. Staff at Fresh Wharf said that problems with intercoms took too long to resolve. A panic alarm at Leyton had been faulty for many months and had been set off approximately 15 times during one recent evening; this required urgent attention as it was unsafe.
- 6.4** At the time of the inspection, 20 cells in Fresh Wharf had been closed due to a malfunction in the air-conditioning system, with significant delays in obtaining a replacement part. In Stoke Newington, five cells were out of use because of their high temperatures during hot weather. In Ilford, staff said that they would close a cell if a detainee complained about the temperature. Despite the hot weather at the time of the inspection, no cells at the other suites had been taken out of use due to poor ventilation, and staff were not carrying out temperature checks in the cells; there was no protocol to check acceptable temperatures in cells. We observed some staff providing detainees with additional cold drinking water due to the heat, but this was not the case in other suites and detainees' needs were not always met adequately.
- 6.5** The cell call bells we tested functioned properly, although custody staff did not always explain to detainees how to use them. Staff told us, and our custody record analysis showed, that staff would mute cell call bells – sometimes for up to an hour – if detainees used them too much. This was an unsafe practice and could increase risks for vulnerable detainees. Both Romford and Forest Gate had outdated manual switches outside each cell to silence the call bell if it was used persistently and/or vexatiously. While this practice was allowed under force policy, the lack of an automated system created potential risk for misuse of bells or mistakes to be made. At Leyton, we saw several delays in responses to cell call bells when

staff were busy with other tasks. At Fresh Wharf, Leyton and Wood Green, staff could speak to detainees in cells through an intercom and transfer calls from family and solicitors, which was a good facility.

- 6.6** Staff had reasonable awareness of the fire evacuation procedures but not all suites displayed fire evacuation plans. We were unable to find evidence of the last fire evacuation drills in some suites, but there were weekly tests of the fire alarm systems. In the emergency evacuation packs we inspected, there were sufficient sets of handcuffs to evacuate detainees safely if required.

Areas for improvement

- 6.7** **Reported defects should be repaired without delay.**
- 6.8** **There should be an agreed protocol to monitor temperatures in cells consistently across the force so that detainees are held in cells with suitable ventilation.**
- 6.9** **Cell call bells should never be permanently muted. Where they are muted, this should be based on a risk assessment and be for the shortest time necessary, closely monitored and reviewed, and the rationale clearly recorded.**

Safety: use of force

- 6.10** It was positive that data on the use of force were collated and disaggregated for custody. The data we saw indicated that the use of force was low relative to the throughput of the custody facilities. The force told us that custody staff received regular and ongoing safety and personal protection training, with sergeants expected to undergo training twice a year and DDOs annually. All the staff we spoke to were in date with their training. Sergeants did not routinely carry any personal safety equipment, which was proportionate in the controlled custody environment. There had been no use of Taser, irritant/incapacitant spray or baton in custody in the previous six months.
- 6.11** Through our case audits, custody record analysis, observations and conversations with staff we identified 19 cases where force had been used since November 2016. We reviewed these in depth and cross-referenced them against CCTV footage. Although individual use of force forms had been introduced, we were not confident from conversations with staff that they all submitted a form following any involvement in the use of force against a detainee. Forms lacked any qualitative information about incidents where force was used. The justification of use of force was mostly reasonable in the custody records, although we found a few accounts that did not fully reflect what we viewed on CCTV footage. We found learning points in two-thirds of the cases, and referred one case back to the force for review.
- 6.12** Our analysis indicated that many staff were very patient, calm and reassuring when dealing with challenging detainees, and that force was generally only deployed as a last resort following efforts to de-escalate situations. However, we had a range of concerns in the incidents we reviewed on the CCTV footage: force was not always proportionate to the threat posed; some techniques were poorly deployed, including some that could potentially injure the detainee; there was some prolonged prone restraint and pressure on the back of detainees in the prone position; too many staff were often involved in restraint unnecessarily; there was poor attention to maintaining the dignity of some detainees; and

detainees already locked in a cell on their own remained in handcuffs – and in leg restraints in one case.

- 6.13** The Metropolitan Police Service North East had piloted the use of spit hoods (MPS terminology is ‘spit and bite guard (SBG)’) in custody suites for three months in 2016-17. There was some confusion among staff, and different interpretations, about when spit hoods should be applied. We looked at CCTV footage for four cases where spit hoods had been applied. We were unable to come to a judgement in one case, but in the other three their use was not proportionate to the risks posed and had not been dynamically risk assessed. Although we were told that all incidents involving a spit hood were reviewed, we did not consider that governance of their use was robust enough.
- 6.14** We often saw detainees arrive into custody in handcuffs, and cases where they remained in place for too long on compliant detainees. This was disproportionate to the threat posed in the controlled custody environment.
- 6.15** Force data for the cluster showed that 14% of detainees who arrived in custody were strip searched, which was slightly higher than we normally see. However, the strip searches we were aware of during the inspection were warranted and properly authorised, which was good. The records also generally indicated the rationale for authorising a strip search, which was positive.

Areas for improvement

- 6.16 All staff involved in the use of force against a detainee should submit an individual use of force form.**
- 6.17 Force should only be used against detainees when necessary and proportionate to the threat posed, should involve the application of appropriate techniques and maintain detainees’ dignity.**
- 6.18 Handcuffs should be removed from compliant detainees at the earliest opportunity.**

Detainee care

- 6.19** Microwave meals, including some vegetarian and other options, and hot drinks were available for detainees. Water was available from kitchen taps rather than drinking fountains. Food preparation areas were generally acceptable, and all suites had some information about meal ingredients and dietary suitability (see paragraph 5.5). Most suites usually provided detainee meals at set times, but we were assured that detainees could also receive food outside of these times if required, and there had been special arrangements for detainees during Ramadan (see paragraph 5.4). In our custody record analysis, 90% of detainees had been offered a meal, including all the 21 held for over 24 hours. We also saw detainees offered something to eat or drink when they were being booked into custody.
- 6.20** No suites had any specific facilities for detainees to receive family visits. Although we were told these could be facilitated in other areas, such as consultation rooms, none of the staff we spoke to could recall this ever happening or provide any example of where it would be likely to.
- 6.21** Mattresses and pillows were routinely provided in all cells and were cleaned between use, although those we saw in cells at Bethnal Green and Fresh Wharf were in generally poor

condition. There were stocks of blankets and some staff, such as at Romford, said they were happy to provide extra blankets to detainees if requested (or move the detainee if they felt their cell was too cold). Although lack of blankets at Wood Green at night time had been a longstanding concern for independent custody visitors (ICVs), we did not observe this problem during our inspection.

- 6.22** Force custody policy required all detainees to be provided with toilet paper on arrival into their cell but this did not always happen, such as at Leyton and Romford, and detainees were expected to request this when required. Handwashing facilities were not available in cells at most suites, except the newer facilities such as Wood Green and Fresh Wharf, and detainees had to ask to leave their cell to use wash basins on cell corridors. However, staff were not always available to facilitate this.
- 6.23** At least one shower was available in every suite and these were generally in good condition (except at Stoke Newington), with good privacy. Some had potential ligature points but these risks were offset by the presence of staff nearby monitoring the detainee. Showers were not offered or provided routinely. In the warm weather during our inspection, it was positive that the custody manager at Fresh Wharf instructed staff to offer all detainees a shower in the morning to be clean for their court appearance. However, this was an exception and we saw several detainees due to go to court who had not been offered this opportunity. Some staff told us they would try to facilitate showers for detainees the night before they went to court, when there was more time and opportunity to do this. However, they conceded that this was not routine practice and that it was not always possible to facilitate showers at any time. We also saw an example of a vulnerable female at Shoreditch who had been held overnight and was wearing soiled clothing who was not offered a shower until we queried this. Our custody record analysis confirmed this lack of provision, with only 11 out of 162 detainees (7%) offered a shower; these findings were only slightly better for detainees held in custody for more than 24 hours, with only four out of 21 (19%) offered a shower, which was poor.
- 6.24** Cotton towels were available in all suites (although supplies at Leyton and Wood Green were limited), along with some toiletries, including toothbrushes, toothpaste, shower gel, combs and razors. There was a good supply of sanitary items for women at most suites, except Wood Green and Romford.
- 6.25** Replacement clothing – T-shirts and tracksuit tops and bottoms – was available for detainees, as well as plimsolls as an alternative to shoes. Stocks were generally good although we found some shortages at Wood Green, the busiest custody suite. Positively, shoe laces and trouser cords were not automatically confiscated from detainees (see paragraph 5.17), which meant they could often continue wearing their own clothes unless these were required for evidential purposes. Replacement underwear was not routinely stocked and held only at Forest Gate (good supplies for both men and women) and Bethnal Green (small stocks for women). Although force custody policy outlined that these items should be bought locally according to demand rather than through core suppliers of other clothing, none of the staff we spoke with were aware of this or how they would obtain such items if required.
- 6.26** Facilities for detainees to exercise were generally poor. Some suites, such as Forest Gate and Stoke Newington, used multi-functional areas primarily intended to hold new detainees coming into custody, which meant the area had to be cleared before a new arrival was expected. Two exercise areas at Romford were no longer used and detainees had to use a very small, caged area that was entirely inadequate; Ilford had a similar facility. However, even where suites had designated exercise areas there were still some problems with detainee access. The area at Bethnal Green was also used to store dirty linen and bedding, which was inappropriate. The facilities in Wood Green, Leyton and Fresh Wharf were inside the main custody buildings and had restricted access to natural light and outside air. Extensive graffiti in the yard at Leyton had not been remedied over a month after being

reported, which showed a lack of respect and the likelihood that detainees used the facility without being closely monitored. The suites were inconsistent in their arrangements for staff to accompany or monitor detainees in exercise areas via CCTV. The areas at Wood Green and Leyton did not have call bells for detainees to contact staff, which meant they would have to rely on staff waiting for them outside (which did not always happen) or use panic alarm strips to alert them, which was poor practice and reduced the impact of this important security tool. Although staff said they would facilitate exercise wherever possible, some acknowledged this was not always feasible, and we did not observe exercise actively offered to detainees during welfare checks. In our custody record analysis, only 2% of detainees – and none of the 21 held for over 24 hours – had been offered exercise.

- 6.27** With the exception of Romford and Forest Gate, suites held a generally limited range of reading materials, with few examples in foreign language or suitable for children. A publicised 'Books in Nicks' initiative between the force and a charity in late 2016, designed to improve the supplies of books in all custody suites and allow detainees to take items with them on release, had not been embedded into practice on the ground. Most suites said they were unaware of the scheme or had not received any new supplies for several months. Although staff said they would offer reading matter to detainees, we did not observe this happening, either when detainees had been booked in or during welfare checks in cells. In our custody record analysis, only 4% of detainees – and again none of the 21 held for over 24 hours – had been offered reading materials.
- 6.28** In general, staff mostly waited for detainees to request access to toilet paper, showers, exercise, reading matter and other provisions. There was little evidence that staff would offer these to make detainees feel as comfortable as possible while in detention, and this was at odds with some of the caring approaches we observed staff use with detainees in other situations.

Safeguarding

- 6.29** We observed custody staff dealing with children and vulnerable adults in a positive and reassuring way. They identified risks appropriately and made arrangements to manage these, including observing these detainees by the CTV screens in addition to observation visits. Specific detention rooms were used to separate children and vulnerable adults from adult detainees, or if these were already in use, cells for women. However, children were not given any priority for booking in and were booked in alongside any other detainees, with no separate facilities to limit their exposure to the custody environment.
- 6.30** Custody staff understanding of safeguarding vulnerable adults and children varied, and they had had limited training in this since their induction as new recruits. There were some policies and procedures covering safeguarding, such as the vulnerability assessment framework and safeguarding referrals, but there was no overarching safeguarding policy for officers to operate to or any specific safeguarding policies for custody.
- 6.31** Arresting and investigating officers were responsible for making safeguarding referrals for children and vulnerable adults, and custody officers had little or no involvement in this. We saw little evidence from custody records or our observations that officers shared any safeguarding concerns with custody sergeants. Although custody sergeants saw their role as covering detainee care and well-being during custody and on release, there was little consideration of how wider safeguarding concerns could impact on risk assessments or a detainee's care needs.
- 6.32** There was some good care for children in custody with recognition of their particular needs. Children could speak with family members by telephone, mental health nurses tried to see

children when possible and check if they were known to services, and there was evidence that care workers were kept updated about children in care. However, girls were not routinely allocated a female officer and most custody staff were not aware of this requirement under the Children and Young Persons Act 1933, as well as in code C of the Police and Criminal Evidence Act (PACE) and the force's own policy. Our custody record analysis showed that in 17 of the 23 PACE reviews carried out the inspectors did not speak with the children face to face, and some case audits recorded that the inspector had not spoken with the child because no appropriate adult (AA) was present. This was poor practice.

- 6.33** Children and vulnerable adults often waited a long time before receiving support from an AA, regardless of whether this was a family member or an independent person. In our custody record analysis, children waited an average of about seven hours before an AA attended with the longest wait being 20 hours and 35 minutes. There were two cases where no AA attended. Our cases audits and observations also indicated long waits. There were similar long waits for AAs for vulnerable adults and cases where no AA was called, despite evidence that this was required. (See recommendation 2.52.)
- 6.34** Record keeping on AAs was generally poor. The detention logs often did not show when an AA was requested, when they arrived or their status (for example, a family member, care worker, an AA from a contracted scheme or a volunteer). It was often only possible to check when an AA had arrived by looking at the time that the rights and entitlements were re-read to the detainee. The service lacked the complete and accurate information to monitor its performance in meeting the needs of detainees, and where improvements were needed.
- 6.35** Most AAs attended at the interview stage rather than to help the detainee understand their rights and entitlements, and to provide early support and reassurance. Custody sergeants often relied on the investigating officers to arrange the AA and did not always oversee this to ensure that AAs were secured promptly. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) had raised this concern in its child protection inspection published in November 2016,¹⁵ and it was disappointing that no progress appeared to have been made.
- 6.36** The arrangements for securing AAs were confusing and varied considerably across the suites. Some local authorities had independent contracted schemes with paid employees, while others used their own staff or volunteers. Some custody suites relied on their own pool of volunteers. As a result, some arrangements offered an all-hours service while others had restricted hours. Some contracted scheme staff could only attend for interview and if a solicitor was present, and could not be called earlier for the rights and entitlements to be read to the detainee. However, once they were called, contracted AAs tended to arrive promptly. These varying arrangements meant inconsistent outcomes for detainees.
- 6.37** Custody staff and other officers tried to contact parents, other relatives or family friends in the first instance to act as an AA. This also resulted in some long waits depending on the willingness and availability of the AA to attend. We saw some good examples where arresting officers had started to make arrangements before the detainee arrived in custody, with custody sergeants making calls to make contact with parents, which did lead to early support in some cases. We also observed some custody officers make clear explanations to AAs about their role and what was expected of them. Some AAs were also given an explanatory AA leaflet, but this did not always happen.

¹⁵ <http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/met-national-child-protection-inspection.pdf>

- 6.38** The force was aware of the problems with the AA service having carried out its own review of custody records. Concerns had been raised at senior officer level but there was no current plan as yet on how to improve the service.
- 6.39** Some children spent a significant time in custody. Force data for the cluster for the year to 31 May 2017 showed that 5,658 children were brought into custody (11% of total throughput), about 40% of whom were detained overnight. Our custody record analysis showed that children spent an average of 14 hours and six minutes in custody, varying from between two and 21 hours, with just under half held overnight. Our case audits and observations indicated similar time periods.
- 6.40** Custody sergeants recognised the importance of keeping children in custody for as little time as possible but we were not assured that all cases were progressed quickly, which was sometimes exacerbated by the delays in AAs arriving. Positively, we saw some cases investigated during the night that resulted in early release for the child. However, most children who arrived in custody at night or in the early hours of the morning were detained overnight. (See recommendation 2.51.)
- 6.41** Children charged and refused bail remained in custody overnight when they should have been moved to alternative accommodation provided by the local authority. Force data for the cluster showed that in the 12 months to 31 May 2017, 449 children were charged and had bail refused. Of these, 310 requests for appropriate accommodation were made to local authorities but only three children were moved. Children charged and refused bail spent an average of 11 hours 32 minutes in police custody after they were charged. In some cases in our case audits, children were held over the weekend, which meant much longer stays in custody.
- 6.42** The force had strengthened its approach to monitoring the detention of children. It monitored the number of children arrested, the number charged, and the number charged and detained because bail had been refused. For the latter, further information was gathered on requests to the local authority for alternative accommodation and their outcome. The case of each child charged and refused bail was scrutinised daily by the central custody team, and senior officers reviewed children detained overnight at regular meetings throughout the day.
- 6.43** There had been some improvements in response to the issues identified – such as training and guidance on secure and non-secure accommodation, improving the recording of requests to local authorities, and ensuring the completion of detention certificates. However, there had been little progress in working with local authorities to ensure that they met their statutory duty to provide alternative accommodation for children. Although the force shared the information it collected with local authorities, this had not yet resulted in any tangible improvements, and there were no procedures to raise the case at more senior level when requests for alternative accommodation were not met. Custody staff were not represented at the local safeguarding children’s boards (LSCBs), which limited any effective strategic oversight. Outcomes for children charged, refused bail and detained overnight remained poor.

Area for improvement

- 6.44** The force should improve its approach to safeguarding vulnerable adults and children by ensuring that custody staff have a clear understanding of their role and are effectively supported by procedures and training. In particular, the force should ensure that:
- all detained girls are assigned a female officer to care for their welfare needs while in custody, in line with the Children and Young Persons Act 1933;
 - PACE reviews of detention for children are carried out face to face, unless this means waking a child during a recognised period of rest;
 - arresting and investigating officers provide safeguarding information on vulnerable adults and children to facilitate custody sergeants in determining a detainee's risk assessment and ongoing care.

Governance of health care

- 6.45** The force provided and managed its own primary health care service, the Met Forensic Health Service (Met FHS). A health needs assessment had been completed in 2015. Clinical governance structures were underdeveloped (see recommendation 2.44). There were no agreed performance targets or outcome measures or regular clinical audits to ensure the service met detainees' needs. The implementation of an electronic clinical recording system to support easier data collection and analysis had been significantly delayed by external factors. Incidents were reported through the force system and investigated by Met FHS; lessons learned informed service delivery and were shared with staff, although we found drug discrepancies that had not been reported. Met FHS had a regularly reviewed improvement plan, but it was not sufficiently comprehensive.
- 6.46** A medical director and nursing director provided clinical leadership across the force, although the demands of recruitment and incident management limited their capacity to provide comprehensive strategic leadership. Three nurse leads supported the nursing director and focused on suites with embedded custody nurse practitioners (CNPs). The medical director had no deputies.
- 6.47** Chronic problems in recruiting and retaining CNPs had consistently hampered plans to develop a predominantly nurse-led service. Twenty-four-hour CNP provision was being introduced at the 12 busiest suites by December 2017, and was improving response times in these suites. During this inspection, Wood Green and Leyton suites had fully embedded provision and Fresh Wharf had partial CNP cover pending full cover from September 2017. Three forensic medical examiners (FMEs) exclusively covered six of the full-time suites we inspected on six-hour shifts, covered CNP gaps and provided medical support to the other three suites.
- 6.48** Waiting times for many detainees to see FMEs were too long and extended their time in custody. In our custody record analysis, half the detainees required a health assessment and the time taken to be assessed ranged up to 11 hours 28 minutes, with an average of two hours 20 minutes. CNPs generally saw detainees within an hour. FMEs had no agreed response times to attend calls linked to clinical and forensic priorities, and responses were affected by the distance between suites and the occasional need to cover additional suites (see recommendation 2.54). If FMEs were unable to attend a suite before their shift ended, custody staff called the next FME at the start of their shift, which was inefficient and created clinical risks. Generally, FMEs saw everyone at a suite who required assessment, which meant that detainees with a greater need at another suite often waited longer. Custody staff said that they sometimes called an ambulance due to long waiting times, but there was no auditing of this to inform service delivery and training needs.

- 6.49** The force directly employed all CNPs. Their access to mandatory training was satisfactory and they were given an additional payment to fund professional development completed in their own time and this recurred the following year if they used it, however most did not take up the option. Access to formal recorded clinical and managerial supervision was mixed. All FMEs were independent contractors, but completed agreed mandatory training annually, including life support and safeguarding, and this was monitored. All new CNPs and FMEs completed the same introductory five-day course, although there had been a gap while a new provider was being secured. During this gap, new CNPs had received additional on-the-job training, plus additional annual leave and funding for extra training, but 19 newly recruited FMEs across the force area could not start work until they completed the new introductory course, which contributed to gaps in FME provision. Health policies were available on the intranet but did not include all aspects of governance and clinical practice.
- 6.50** Clinical rooms had been refurbished in all suites and were generally of a satisfactory standard. However, there were some non-compliant fixtures and fittings, many rooms had excess clutter on surfaces and cleaning standards were generally inadequate (except at Wood Green). Clinical rooms did not have an NHS-equivalent cleaning schedule and the last formal infection control audit had been in 2014. Most clinical rooms contained appropriate clinical equipment and in-date stock, although we found expired forensic testing kits in Stoke Newington and Bethnal Green.
- 6.51** The police complaints system was used for health care complaints, which was insufficiently confidential, and there was no material advising detainees on how to give feedback on their health care.

Areas for improvement

- 6.52 Health staff should have access to an appropriate range of regularly reviewed and evidence-based clinical and corporate health-specific policies.**
- 6.53 All clinical rooms should be cleaned to NHS-equivalent standards using an agreed cleaning schedule, which should be audited regularly.**
- 6.54 Detainees should be able to complain about health services through a well-advertised, confidential health complaints system.**

Patient care

- 6.55** Custody staff referred detainees to health professionals based on need or a detainee's request. Joint working between custody and health staff was effective. Custody staff were positive about the health care provided for detainees, and the care we observed was good. However clinical room doors were routinely left open during consultations without an individual risk assessment, and DDOs were usually in or just outside the room, which compromised detainee privacy. Access to a female health care professional for women detainees was not advertised, and we were told could not be facilitated in some instances. Professional interpreting was used appropriately for detainees with limited English.
- 6.56** CNPs completed an electronic custody health assessment plan (CHAP) and summarised consultations on to the NSPIS (national strategy for police information systems) electronic police recording system. Those we examined were generally good. FMEs completed an entry on NSPIS only and stored their own handwritten records off site, which created concerns about information governance and data protection. This practice also meant that not all clinical records were accessible, which affected continuity of care, and clinicians often wrote

additional confidential clinical information on NSPIS as a handover, leading to possible breaches of medical confidentiality (see paragraph 7.11 and area for improvement 7.14). Many of the FME NSPIS records were too brief. There was some sampling of clinical records but this was not sufficiently regular or wide enough for effective governance. We found medical record logbooks containing confidential clinical records lying on surfaces in several clinical rooms, which was unacceptable.

- 6.57** Police tried to retrieve medication from detainees' homes where appropriate; health staff assessed the detainee and checked the medicine before administration, which was positive. Systems to obtain other required medicines were appropriate. Detainees on methadone prescriptions for opiate addiction could not always continue their prescription; only FMEs were allowed to administer it and not all would do so. Symptomatic relief for drug and alcohol withdrawal was satisfactory. Nicotine replacement therapy was not available, which might have exacerbated the distress of detention for those who smoked. Medication administration was safe. Detainees' medication was generally stored securely, except at Shoreditch where it hung on a clipboard on the wall. Health staff could access detainee's NHS summary core record to confirm medication, which supported continuity of care.
- 6.58** Custody sergeants were responsible for ordering and checking stock medication, except at Fresh Wharf, Wood Green and Leyton where CNPs took the lead. Stock was generally standardised across the suites. Most medicines were in date and stored securely and tidily, but we found some expired items at Ilford and Stoke Newington, and at Shoreditch medicine storage was very disorganised with many expired items. Some FMEs carried their own additional medicines, without adequate clinical justification or governance. We observed that the security of drug cupboard keys was not maintained in every suite.
- 6.59** Custody sergeants or CNPs counted stocks of diazepam and dihydrocodeine (medicines used for alcohol and opiate withdrawals) daily. Records indicated that errors were identified promptly; most were recording issues but we found instances where missing tablets were unaccounted for. Discrepancies were investigated locally but not all drug errors were reported to Met FHS to inform service improvement.
- 6.60** There were no regular clinical audits of medicine storage and records. Only medicine use by CNPs was monitored, resulting in inadequate prescribing data to inform effective medicines management. The medicines management committee met too infrequently. A new medicines policy was being developed.

Areas for improvement

- 6.61** **Health consultations should always take place in private, unless a recorded risk assessment indicates this is not appropriate.**
- 6.62** **All health professionals should record on one shared core clinical record, and clinical record keeping and storage should be in line with professional standards, the Data Protection Act and Caldicott guidelines on confidentiality.**
- 6.63** **Detainees who smoke should have prompt access to nicotine replacement therapy if clinically appropriate.**
- 6.64** **Medication management processes, including the security of keys, reconciliation of stock and access to drug cupboards, should always meet current professional standards and be verified by regular audits.**

Substance misuse

- 6.65** Support for detainees with substance misuse needs was generally good. Each suite provided target drug testing for heroin, cocaine and crack-cocaine linked to trigger offences and inspector authorisation. Detainees testing positive were required to have two substance misuse appointments. A central MPS team effectively monitored the target testing programme.
- 6.66** Five substance misuse services provided input across the nine suites. Most services, except Lifeline at Leyton, visited the suite at least daily to offer voluntary support to detainees with drug and alcohol issues and support the target testing service. Embedded provision at Wood Green, Ilford (Blenheim Community Drug Project) and Bethnal Green (Tower Hamlets Council) was impressive.
- 6.67** Substance misuse staff worked effectively with custody and health staff, but they could not make entries on the custody records, which meant some that contacts were not recorded. There was no access to clean injecting equipment in the suites, but substance misuse staff could signpost detainees to local needle exchange programmes. Children with substance misuse issues were referred or directed to local age-appropriate services.

Area for improvement

- 6.68** **Substance misuse practitioners should be able to record their contact with detainees on custody records.**

Mental health

- 6.69** Custody staff we spoke to demonstrated a good understanding of mental health issues and said they received informal input from health staff, which they found helpful. Custody and liaison and diversion staff had provided two-way training in 2014/15, which had supported the shared understanding of each other's responsibilities and roles. Custody staff were able to attend mental health awareness training on women in custody provided in July 2017.
- 6.70** Liaison and diversion services supporting detainees of all ages and vulnerabilities were provided across all nine suites. However, due to staffing levels and clinical need, practitioners often had to prioritise acute severe mental illness and children. Due to the high demand, Barnet, Enfield and Haringey Mental Health NHS Trust provided one to two practitioners in Wood Green on weekdays from 8am to 8pm, and Together for Mental Wellbeing provided a practitioner at the Fresh Wharf, Ilford and Romford suites between 8am and 8pm on weekdays and 10am to 5pm on Saturday, although sometimes there was only one practitioner across the three suites. During the inspection, the Ilford practitioner was also covering Romford due to staffing issues. East London NHS Foundation Trust covered the remaining five suites with each practitioner covering two suites on weekdays between 8am and 9pm, although there were usually two practitioners in the afternoon due to shift overlap.
- 6.71** Detainees were seen following referral from custody or health staff or from active screening of available records. Custody staff were very positive about the service, and there was good partnership working with all key stakeholders. Assessed detainees could be referred to a community support worker for time-limited support in the community if required. Practitioners made entries in the custody record, which supported effective information sharing. In the six months to March 2017, over 1,500 detainees were seen by the service across all nine suites, with Wood Green accounting for almost a third, most for mental health issues. Shoreditch, Stoke Newington and Wood Green benefited from a part-time

specialist youth practitioner, although during the inspection this was not available at Wood Green due to staff sickness.

- 6.72** Reports from health, mental health and custody staff, plus the limited data available, indicated that most detainees requiring a Mental Health Act assessment were seen within three hours and most were then transferred to a mental health bed promptly, although a significant minority of detainees experienced some long delays. This included one person in 2016 who was held in custody as a place of safety under section 136 of the Mental Health Act¹⁶ for an additional 68 hours after the need for a voluntary mental health admission was agreed, due to a lack of beds. There were clear systems to escalate problems to the Met Mental Health Team and these issues were then reviewed with community providers and the NHS Safety Executive to improve the service, although not all delays were reported to them. Recognised inconsistencies in practice and regular delays in detainees accessing treatment had led to the development of a pan-London framework, due to be launched, involving all key health, local authority, police and ambulance service stakeholders to provide consistent care, including escalation processes and agreed response times to assessment and transfer.
- 6.73** In 2017, no individual had been detained in North and North East MPS police custody under section 136, as the use of police custody as a place of safety was actively discouraged.

Area for improvement

- 6.74 Detainees with mental health issues should receive prompt assessments, and agreed transfers to hospital facilities should take place without delay.**

¹⁶ 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 Mental Health Practitioner, and for the making of any necessary arrangements for treatment or care.

Section 7. Release and transfer from custody

Expected outcomes:

Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

- 7.1** Custody sergeants spoke to all detainees before their release and we observed some efforts to release them safely. However, the pre-release risk assessment checklist, 'hard facts', was too limited. Staff were not given sufficient guidance or any detailed prompts in how to carry out the pre-release risk assessment, and so its completion was inconsistent and in some cases cursory.
- 7.2** Our custody record analysis and case audits did not provide sufficient evidence of comprehensive pre-release risk assessments being completed on detainees. Records lacked detail and did not include information showing that identified risks for detainees had been addressed or offset before their release. In too many cases, recording was poor and did not reflect the staff care and attention to detainees that we observed, and we were unable to determine how some detainees got home. Despite this, some custody sergeants took the time before release to discuss concerns that detainees had about their welfare.
- 7.3** Detainees were usually given a generic support leaflet with useful telephone numbers on their release. Although two further leaflets offering information about domestic violence or contact details for veterans' support services were available, not all staff were aware of these, and they also did not know that all the leaflets were available in nine different languages. At Leyton and Fresh Wharf, the Prince's Trust pilot referral scheme to support 16-30 year olds who had been arrested was a promising initiative, and at Leyton 11 referrals had been made to the project in the previous six weeks. Information promoting the project was displayed around the Leyton suite and staff had good knowledge of it.
- 7.4** Sergeants usually enquired how detainees were getting home, although travel warrants were not available in all suites and there was no access to petty cash to pay for transport if detainees had no money. We were not assured that all detainees were released safely as staff told us that some detainees released into areas they did not know were expected to find their own way home. One woman released in the early hours of the morning was unsure how to get home, and was told to walk to a taxi company close by. Another detainee who had been on a constant watch was released just before midnight without any staff checks about his welfare after release. Custody staff said, and our case audits showed, that they arranged for police officers to provide transport to get children home safely

Areas for improvement

- 7.5** The pre-release risk assessment should include additional questions that identify any risks or welfare concerns for detainees to ensure their safe release.
- 7.6** There should be support to pay for transport for detainees who do not have the means to get home on release.

Courts

- 7.7** The custody suites inspected were served by four courts - Highbury Corner, Thames, Barkingside and Stratford (youth). Detainees were generally sent to the nearest court, subject to availability. However, although the Romford suite was next door to Romford Magistrates' Court, detainees were not sent there (unless for full trial) but to Barkingside instead for their initial court appearance.
- 7.8** Staff reported generally good relationships with courts and that detainees were usually accepted up to 3pm on weekdays, provided that they were taken to the court by 2pm to 3pm. We observed this being achieved on several occasions, with some exceptions. In one case, custody staff liaised with Thames Magistrates between 12.30pm and 1pm to pursue appearances for two detainees arrested and remanded to appear there on unrelated matters, but were told there was no availability until the following day. In addition to securing a space at the court, the detainee's appearance relied on custody staff making arrangements with investigating or other officers to escort the individual there, due to the lack of Serco escorts following the early morning court transfer. We observed this in practice at Forest Gate, where custody staff arranged for investigating officers to take an additional detainee to appear at the same court that afternoon.
- 7.9** Staff at Romford reported a poorer service than at the other suites, and that it was usually not possible to arrange a court appearance after 1pm – which could be even earlier on Mondays, when the Barkingside court was processing detainees held over the weekend. However, we did not see this in practice.
- 7.10** Force custody policy provided staff with a clear process on how to complete person escort records (PERs). Both designated detention officers (DDOs) and custody sergeants were trained in how to complete these, although all forms had to be authorised by a sergeant. Although the forms were intended to present an accurate picture of the detainee's known risks and condition for escorting staff, staff at some suites (including Wood Green and Fresh Wharf) completed forms the day before the detainee's departure with the expectation that they would be updated and checked; some staff acknowledged that risks could be missed in this practice.
- 7.11** The forms that we checked were of variable quality. All were directly cross-referenced with detainees' custody records and police national computer records, and some were completed to a good standard with appropriate detail highlighting relevant risks. However, many failed to provide sufficient information on dates or contextual details. We also identified that staff did not always understand the required process; some failed to record accurately the additional documents accompanying each record (as required by policy), or to store any confidential medical information included appropriately.

Areas for improvement

- 7.12** **The force should ensure that detainees are not held longer at Romford than at other suites due to local court arrangements.**
- 7.13** **All custody staff should complete person escort records according to the appropriate procedure.**
- 7.14** **All medical information accompanying detainees going to court, including medical records and assessments, should be placed in a sealed envelope marked 'confidential'.**

Section 8. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

8.1 Area of concern: Too many children charged and refused bail remained in custody overnight, and sometimes the weekend, when they should have been moved to alternative accommodation provided through the local authority.

Recommendation: The force should agree arrangements with local authority partners to avoid the overnight detention of children in custody by their transfer to suitable alternative accommodation. These arrangements should include procedures to escalate cases, with strategic monitoring and oversight by the force and with partners on local safeguarding children's boards. (2.51)

8.2 Area of concern: The arrangements for obtaining appropriate adults did not ensure that all children and vulnerable adults received early and effective support.

Recommendation: The force should ensure that appropriate adult (AA) services are prompt and effective, and work with local authority partners to deliver consistent outcomes for detainees. There should be early support to detainees, with access to 24-hour services when needed. Records of AA request and arrival times and their status should be recorded accurately on custody records, with the information used to assess outcomes for detainees. (2.52)

8.3 Area of concern: Inspectors did not conduct PACE reviews adequately for the purpose of detainees' detention and welfare, but instead for their own convenience.

Recommendation: The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984. (2.53)

8.4 Area of concern: The lack of agreed response times by forensic medical examiners (FMEs), linked to clinical and forensic priorities, meant that some detainees with the greatest health need were not always seen promptly, creating a significant risk of poor health outcomes. The lack of clear performance targets and outcome measures, and underdeveloped clinical governance, resulted in inadequate oversight and monitoring of health provision.

Recommendation: Detainees should be seen by forensic medical examiners (FMEs) within agreed response times that are linked to clinical and forensic priorities. There should be robust clinical governance, including performance targets, outcome measures and clinical audits, to ensure the health needs of detainees are consistently met. (2.54)

Areas for improvement

Leadership, accountability and partnerships

- 8.5** The force should ensure that all staff are aware of and adhere to the force custody toolkit. (3.8)
- 8.6** The force should have sufficient staff in all roles to ensure the safe delivery of custody. (3.9)

Pre-custody: first point of contact

- 8.7** Frontline officers should have sufficient and timely information from police intelligence systems to underpin their risk assessments and inform their decision making when dealing with incidents. (4.9)

In the custody suite: booking in, individual needs and legal rights

- 8.8** There should be a consistent and robust force-wide system to monitor detainee observations so that visits to cells are on time and risk is managed effectively. (5.18)
- 8.9** There should be a protocol to manage the allocation of cell keys. (5.19)
- 8.10** Shift handovers should include all relevant staff and take place in sufficient privacy. (5.20)
- 8.11** The Metropolitan Police Service should monitor the average waiting times for detainees from their time of arrival into custody to authorisation of their detention to ensure that detainees are booked in promptly on arrival. (5.34)
- 8.12** Custody sergeants and designated detention officers should ensure that the detainee's correct time of arrival is recorded accurately on custody records. (5.35)
- 8.13** The Metropolitan Police Service should monitor detention times to ensure that detainees are dealt with quickly and are released as soon as the need for detention no longer applies. (5.36)
- 8.14** DNA and other evidential samples should be submitted in good time, and refrigerators and freezers for samples in the custody suites should store only appropriate items. (5.37)

In the custody cell, safeguarding and health care

- 8.15** Reported defects should be repaired without delay. (6.7)
- 8.16** There should be an agreed protocol to monitor temperatures in cells consistently across the force so that detainees are held in cells with suitable ventilation. (6.8)
- 8.17** Cell call bells should never be permanently muted. Where they are muted, this should be based on a risk assessment and be for the shortest time necessary, closely monitored and reviewed, and the rationale clearly recorded. (6.9)
- 8.18** All staff involved in the use of force against a detainee should submit an individual use of force form. (6.16)

- 8.19** Force should only be used against detainees when necessary and proportionate to the threat posed, should involve the application of appropriate techniques and maintain detainees' dignity. (6.17)
- 8.20** Handcuffs should be removed from compliant detainees at the earliest opportunity. (6.18)
- 8.21** The force should improve its approach to safeguarding vulnerable adults and children by ensuring that custody staff have a clear understanding of their role and are effectively supported by procedures and training. In particular, the force should ensure that:
- all detained girls are assigned a female officer to care for their welfare needs while in custody, in line with the Children and Young Persons Act 1933;
 - PACE reviews of detention for children are carried out face to face, unless this means waking a child during a recognised period of rest;
 - arresting and investigating officers provide safeguarding information on vulnerable adults and children to facilitate custody sergeants in determining a detainee's risk assessment and ongoing care. (6.44)
- 8.22** Health staff should have access to an appropriate range of regularly reviewed and evidence-based clinical and corporate health-specific policies. (6.52)
- 8.23** All clinical rooms should be cleaned to NHS-equivalent standards using an agreed cleaning schedule, which should be audited regularly. (6.53)
- 8.24** Detainees should be able to complain about health services through a well-advertised, confidential health complaints system. (6.54)
- 8.25** Health consultations should always take place in private, unless a recorded risk assessment indicates this is not appropriate. (6.61)
- 8.26** All health professionals should record on one shared core clinical record, and clinical record keeping and storage should be in line with professional standards, the Data Protection Act and Caldicott guidelines on confidentiality. (6.62)
- 8.27** Detainees who smoke should have prompt access to nicotine replacement therapy if clinically appropriate. (6.63)
- 8.28** Medication management processes, including the security of keys, reconciliation of stock and access to drug cupboards, should always meet current professional standards and be verified by regular audits. (6.64)
- 8.29** Substance misuse practitioners should be able to record their contact with detainees on custody records. (6.68)
- 8.30** Detainees with mental health issues should receive prompt assessments, and agreed transfers to hospital facilities should take place without delay. (6.74)

Release and transfer from custody

- 8.31** The pre-release risk assessment should include additional questions that identify any risks or welfare concerns for detainees to ensure their safe release. (7.5)
- 8.32** There should be support to pay for transport for detainees who do not have the means to get home on release. (7.6)

- 8.33** The force should ensure that detainees are not held longer at Romford than at other suites due to local court arrangements. (7.12)
- 8.34** All custody staff should complete person escort records according to the appropriate procedure. (7.13)
- 8.35** All medical information accompanying detainees going to court, including medical records and assessments, should be placed in a sealed envelope marked 'confidential'. (7.14)

Section 9. Appendices

Appendix I: Inspection team

Ian MacFadyen	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMICFRS inspection lead
Anthony Davies	HMICFRS inspection officer
Adrian Gough	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Andrew Reed	HMICFRS inspection officer
Majella Pearce	HMI Prisons health services inspector
Nicola Rabjohns	HMI Prisons health services inspector
Matthew Tedstone	Care Quality Commission inspector
Anna Fenton	HMI Prisons researcher
Helen Ranns	HMI Prisons researcher