



Report on an unannounced inspection visit to police
custody suites in

Metropolitan Police Service

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

9–20 July 2018

This inspection was assisted by an inspector from the Care Quality Commission (CQC) in assessing health services under our memorandum of understanding.

Glossary of terms

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Contents

Fact page	5
Executive summary	7
Introduction	13
Section 1. Leadership, accountability and partnerships	15
Section 2. Pre-custody: first point of contact	19
Section 3. In the custody suite: booking in, individual needs and legal rights	21
Section 4. In the custody cell, safeguarding and health care	31
Section 5. Release and transfer from custody	41
Section 6. Summary of causes of concern, recommendations and areas for improvement	43
Section 7. Appendices	47
Appendix I: Methodology	47
Appendix II: Inspection team	49

Fact page¹

Force	Metropolitan Police Service (MPS)
Commissioner	Commissioner Cressida Dick
Police and Crime Commissioner	Mayor of London
Geographical area	Greater London
Date of last police custody inspection	(MPS North and North East) 19–30 June 2017
Custody suites	Cell capacity
Acton	22 cells
Bromley	30 cells
Charing Cross	42 cells
Heathrow	30 cells
Holborn	16 cells
Hounslow	12 cells
Islington	24 cells
Kingston	20 cells
Lewisham	33 cells
Plumstead	24 cells
Southall	11 cells
Walworth	30 cells
Belgravia (contingency suite)	12 cells
Peckham (contingency suite)	18 cells
West End Central (contingency suite)	28 cells
Annual custody throughput	64,429 detainees (1.717-30.6.18) (164,477 detainees across the MPS estate for the same period)
Custody staffing	62 inspectors, 188 sergeants (+20 on restricted duties) and 244 designated detention officers (+22 on restricted duties)
Health service provider	Metropolitan Police Forensic Healthcare Service (delivered in house)

¹ Data supplied by the force.

Executive summary

- S1 This report describes the findings following an inspection of 12 full-time and three contingency suite custody facilities in the Metropolitan Police Service (MPS) in July 2018. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in July 2018, as part of their programme of inspections covering every police custody suite in England and Wales.
- S2 The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.
- S3 This was the third in a series of inspections in the Metropolitan Police Service that ensured that all 27 operational custody suites and additional contingency suites had been inspected since 2015. We did not follow up recommendations made at either of the previous inspections in 2015 or 2017.
- S4 To aid improvement we have identified several key causes of concern and areas for improvement. This report provides two recommendations to the force and the Mayor of London (the Police and Crime Commissioner) and highlights 23 areas for improvement. These are set out in full in Section 6.

Leadership, accountability and partnerships

- S5 There were many positive features in this inspection of custody facilities ('Met Detention') in the MPS. Although we did not follow up recommendations made during our previous inspections of MPS custody facilities in 2015 and 2017, because they covered different custody suites, there was evidence of some general progress across Met Detention since our last visit. In this inspection we identified two causes of concern and several areas requiring improvement, which we were confident the force would be able to address.
- S6 There was a clear governance structure that provided accountability for custody services. Custody staff were generally well trained, and the force was committed to their ongoing development. The staffing of custody suites, however, remained a challenge. During the inspection, there was a significant number of staff vacancies across all ranks, from designated detention officers (DDOs) to inspectors. While overtime was mostly used to cover shortfalls in staffing, this was not sustainable. In addition, custody staff were not always deployed effectively, and a lack of direction by inspectors and sergeants led to varying practices and inconsistent outcomes for detainees.
- S7 The force had adopted *Authorised Professional Practice* (APP) for custody as set by the College of Policing. This was supplemented by a clear custody policy 'toolkit'. However, in practice, not all staff had a good understanding of force policies and procedures, and did not always follow them consistently.
- S8 The collation and monitoring of performance data on custody were generally good, and the force well understood most areas of performance. Apart from a few areas, there was generally good compliance with the Police and Criminal Evidence Act (PACE) and its codes of practice.
- S9 The force placed a strong emphasis on diverting children and vulnerable people from custody. There was a clear commitment to engaging with a vast range of partners to improve

outcomes for detainees, but some arrangements, especially in relation to children, were still underdeveloped. However, the force continued to make improvements in the treatment of detainees with mental ill health, and as a result only one person had been detained in custody under section 136 of the Mental Health Act² in 2018 to date.

Pre-custody: first point of contact

- S10 Frontline officers had a good understanding of vulnerability and took account of this for individuals when determining whether or not to arrest them. However, officers told us that the information provided by the call centres to inform their decision-making was of variable quality and often limited. This had not improved since our previous inspection of custody suites in the MPS.
- S11 The police staff we spoke to also said that information from partner agencies was limited and variable across London, particularly for mental health. Frontline officers did not take individuals detained under section 136 to custody but they often struggled to get assistance in accessing beds in mental health facilities. This meant that they often waited with detainees for lengthy periods before they were admitted to a health-based place of safety. Similarly, officers believed that there was little support to help them deal with individuals who had committed offences but who were also displaying mental ill health. They told us that they sometimes had no choice but to arrest so that detainees could access the appropriate support in custody, because they were unable to arrange a health-based alternative.
- S12 Frontline officers were properly focused on diverting children from custody and told us they would consider a range of alternatives, where possible. However, their priority was to safeguard the child, and for some children who were involved in serious, violent and gang-related crime, custody was seen as the best option to ensure arrangements could be put in place to protect them.

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

- S13 Custody staff interacted and engaged with detainees respectfully and showed regard to their dignity. Apart from the custody suites at Heathrow and Islington, booking-in areas were poorly screened, with insufficient privacy for detainees to disclose sensitive or confidential information.
- S14 Custody staff told us they had received only limited training to help them meet the specific needs of detainees with protected characteristics. Despite this, they demonstrated a generally good awareness and understanding of how they would identify and manage the individual and diverse needs of those who came into custody. However, this awareness did not always translate into good outcomes for all detainees. The specific needs of female detainees were not always met, including the range of sanitary products provided. Arrangements for detainees with disabilities were largely poor. Facilities for religious worship were inconsistent across the suites, and did not always include the appropriate artefacts.
- S15 The force's approach to managing risk was generally measured and proportionate. Initial risks were identified and mostly managed well. It was positive that Met Detention custody staff approached the management of risk case by case, with no routine removal of detainees'

² 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 their treatment or care.

footwear/laces or clothing with cords. In particular, there was no use of anti-rip clothing, as staff recognised that the risk of self-harm could be managed effectively in other ways to avoid confrontation and minimise distress to detainees. However, initial observation levels set, particularly for intoxicated detainees, did not always match the risks presented. Although we were concerned that intoxicated detainees were not always placed on an appropriate level of observation and that there was some non-specific recording of the times that routine observations took place, checks were generally carried out at the required frequency. Where the set observation level designated the rousing of intoxicated detainees, this was conducted and documented appropriately. However, cell visits were not always carried out by the same DDO, which made it harder to note any changes in a detainee's behaviour or mood over time. Staff did not always respond to cell call bells promptly, and they sometimes muted them without good justification or proper authority. The quality of staff shift handovers was inconsistent.

- S16 Waiting times for detainees to be booked in were mostly good, although some detainees waited too long. The circumstances and grounds for arrest were, in the main, well explained before detention was authorised. Detainees generally had their rights and entitlements explained to them in a format and language they understood. Cases were, however, not always progressed promptly. Delays in allocating and carrying out investigations, and in securing the attendance of appropriate adults (AAs), sometimes prolonged the time that detainees spent in custody unnecessarily.
- S17 The overall standard of PACE reviews of detention was good, and much improved since our last inspection. Most were timely and conducted in the best interests of the detainee, including a focus on their care and welfare in custody.
- S18 The custody responsibilities for bail were managed well. However, detainees released from custody under investigation (RUI) were not always given sufficient explanation of what this meant or the implications.
- S19 There was little emphasis on the detainees' right to complain while in custody. Custody staff gave us mixed responses on how they would deal with detainee complaints. This did not assure us that complaints would be dealt with before a detainee left custody.

In the custody cell, safeguarding and health

- S20 Although most of the estate was old and dated, conditions and cleanliness in the custody suites we inspected were generally good. There was minimal graffiti, all cells had natural light, suitable temperatures and working call bells. We did, however, find several potential ligature points in the suites inspected. Some remedial work began while we were inspecting, and the force subsequently responded positively to the comprehensive illustrative report we gave them on the potential ligature points we found. The estate further suffered from a lack of facilities, such as in-cell sinks, discrete or adequately screened booking-in areas, exercise yards, accessible toilets and showers, and sufficient CCTV coverage. Fire evacuation procedures were rarely practised, and there was insufficient attention paid to fire safety.
- S21 Custody staff were generally patient and sensitive when dealing with challenging detainees. Officers were clearly focused on de-escalating situations before force was used against detainees. However, when force was used, the governance and oversight of incidents were not adequate, and the MPS did not have appropriate mechanisms to assure itself, the Mayor's Office for Policing and Crime (MOPAC) and the public that the use of force in detention and custody was safe and proportionate. We found some inaccuracy, as well as under-reporting, of the use of force, and not all officers submitted individual use of force forms, as required. Some of the cases we reviewed were well managed, but there were learning points in others.

Our main concerns related to the length of time some detainees remained in 'spit and bite' guards (spit hoods), poor techniques, and the proportionality of some of the force used for the risks posed.

- S22 Force data indicated that the numbers of strip searches were high, and included many children and a significantly higher proportion of black and minority ethnic detainees compared against the overall throughput. We concluded that overall not all strip searches were warranted or properly justified.
- S23 Detainees told us that they were generally cared for well during their time in custody. A sufficient range of food and drinks was available and offered readily. Detainees mostly wore their own clothing, but when this was not feasible there were sufficient stocks of suitable alternatives. Other aspects of detainee care were, however, inconsistent and generally offered only on request rather than routinely. But even when detainees knew what they could ask for, few had access to basic facilities and amenities, such as handwashing, showers, reading materials and time out of cell for fresh air or exercise.
- S24 The force had a clear priority on safeguarding children and vulnerable adults. But while several areas of safeguarding and care for children had improved, some of the concerns we raised in 2017 remained. Girls were generally allocated a female member of staff, in line with the Children and Young Persons Act 1933. Custody staff engaged well with children and generally showed them good care during their detention. However, although custody sergeants recognised that AAs should be called as soon as practicable, children and vulnerable adults were still not always receiving early support from AAs. Children entering custody were actively monitored and there was some good engagement with partner agencies. Despite this, outcomes for most children who were charged and refused bail were poor, as they generally remained in custody overnight because there was very little alternative accommodation for them to move to.
- S25 There was little strategic oversight for the provision of health care, which had resulted in an inconsistent service across the custody estate. Not all suites had embedded 24-hour cover from a health care professional, and this had led to some long waits, an inequitable service and some poor outcomes for detainees. Clinical governance arrangements were mixed. While nurse staffing numbers, skill mix and competence, and some aspects of health provision, had improved, and clinical rooms were appropriate, there was a lack of governance of confidential health complaints, integrated clinical incidents systems and quality assurance of practice. Individual care for detainees was good and delivered by competent practitioners but often lacked sufficient confidentiality. Apart from Lewisham, none of the suites had in-suite support for substance misuse; this was a gap in provision that limited prompt access to treatment for detainees who had identified need, or were held on suspicion of drug-related offending.
- S26 The mental health support in custody was variable. Where available, the input was reasonable and valued by custody staff. Where detainees required a mental health assessment under the Mental Health Act, these were timely but there was some slippage, particularly out of hours. This meant that some detainees had excessive delays waiting for assessments and, for those needing inpatient beds, there were often delays in locating and taking detainees to them.

Release and transfer from custody

- S27 There was no consistent focus on ensuring that all detainees were released safely, including some who posed a higher risk. Arrangements for children and vulnerable adults were better, although some who relied on the police to take them home experienced long waits. All

detainees were routinely given a generic support leaflet on their release but it was not always explained. There was a lack of readily available travel warrants and no petty cash to assist detainees without sufficient means to get home. The practice of giving detainees their custody front sheet to secure free public transport breached their confidentiality.

- S28 Some courts imposed too early cut-off times for accepting detainees, which resulted in some spending unnecessary overnight stays in custody. Arrangements for collecting and taking detainees to court before cut-off times were acceptable and generally worked well.
- S29 'Virtual' courts, with video links between the suite and the court, were operated in two suites by designated custody staff. Courts did not generally prioritise police custody cases for hearings and cases were often heard late into the afternoon. However, if individuals were remanded to prison they were generally taken there the same day.

Causes of concern and recommendations

- S30 **Cause of concern:** The governance and oversight of the use of force in custody were not adequate to ensure that all use of force was proportionate and justified for the risk or threat posed. Not all use of force in custody suites was recorded, or the force used was not always accurately reflected in the custody record. Not all staff involved in use of force incidents completed individual use of force forms.

Recommendation: All use of force in the custody suites should be recorded, accurately reflect the force used, and be fully justified on the custody record. Governance and oversight of the use of force should ensure that all use of force is proportionate to the risk posed, and include comprehensive review of CCTV records.

- S31 **Cause of concern:** Strategic oversight of the provision of health care was poor, outcomes for detainees were inconsistent, and not all detainees received prompt access to medical care.

Recommendation: The force should have robust oversight of the delivery of health care services and assess the outcomes achieved for detainees. All detainees should receive a consistent service and have prompt access to medical care.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary & Fire and Rescue Services (HMICFRS). 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. HMIP and HMICFRS are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force is fulfilling its responsibilities for the safe detention and respectful treatment of those detained in police custody, and the outcomes achieved for detainees.

Our assessments are made against the criteria set out in the *Expectations for Police Custody*.³ These standards are underpinned by international human rights standards and are developed by the two inspectorates, widely consulted on across the sector and regularly reviewed to achieve best custodial practice and drive improvement.

The *Expectations* are grouped under five inspection areas:

- Leadership, accountability and partnerships
- Pre-custody: first point of contact
- In the custody suite: booking in, individual needs and legal rights
- In the custody cell: safeguarding and health care
- Release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody*.⁴

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For the Metropolitan Police Service (MPS) we analysed a sample of 167 records. The methodology for our inspection is set out in full at Appendix I.

The joint HMIP/HMICFRS national rolling programme of unannounced police custody inspections, which began in 2008, ensures that custody facilities in all 43 forces in England and Wales are inspected, at a minimum, every six years.

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Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

³ <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

⁴ <https://www.app.college.police.uk/app-content/detention-and-custody-2/>

Section 1. 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

- I.1** The Metropolitan Police Service (MPS) had a clear governance structure for custody. A dedicated detention command (Met Detention) provided central support and oversight across the force and had overall responsibility for the custody function. It was supported by specialist staff trained to deliver custody services. This structure provided clear accountability for the safe delivery of custody.
- I.2** The force had effective internal meetings to oversee custody provision and provide appropriate governance. Progress had been made in a number of areas since our last inspection in 2017,⁵ resulting in improved outcomes for detainees. However, strategic engagement with external partners to drive improvement and provide effective scrutiny of services for custody remained limited. As in our previous inspection, it was not always clear whether it was the detention command or borough policing that had responsibility for engaging with partners. This meant that custody services were not always represented at meetings to raise their priorities and concerns, for example in relation to local authorities' responsibilities to provide alternative accommodation for children held in custody.
- I.3** At the time of the inspection, there were insufficient resources to ensure safe detention. Custody services had vacancies for inspectors, sergeants and designated detention officers (DDOs), and some staff were on restricted duties. This had led to an over-reliance on officers at all levels working overtime to ensure sufficient staffing in the suites, including acting inspectors covering the duties of substantive inspectors.
- I.4** Despite the force's efforts, the staffing of the custody suites had not improved since our last inspection, and for sergeants and inspectors had deteriorated. There was a significant shortage in the number of DDOs. The establishment figure of 725 across the force was not met, with only 595 DDOs at the time of the inspection and only 266 DDOs in the suites we inspected, which were also experiencing shortages. The force was seeking to address these shortages but the high staff turnover due to many DDOs successfully applying to become police officers had made this a challenge. The arrangements for staffing were not sustainable and needed to be addressed.
- I.5** Staff on duty in the suites were not always deployed effectively. There was often a lack of direction by inspectors and sergeants to prioritise and organise work in a way that best met demand. It was not always clear where responsibility for tasks lay, and DDOs performed different roles depending on their team and custody suite, with the potential for inconsistent outcomes for detainees.

⁵ We inspected some MPS custody suites in 2017. Although this inspection covered different suites, there are several common themes and issues that apply across the custody estate. Progress against these has been reflected where relevant.

- I.6** The force had adopted *Authorised Professional Practice* for custody as set by the College of Policing. This was enhanced by a clear custody policy 'toolkit', which was user-friendly and provided guidance to staff in custody service provision. In practice, not all staff demonstrated a good understanding of force policies and procedures, and did not consistently follow them.
- I.7** The force provided comprehensive training that custody officers and DDOs had to complete before undertaking duties. However, some staff said that this had not prepared them sufficiently. It was not clear if new staff always received a period of shadowing more experienced officers before starting their role.
- I.8** There was ongoing training through four mandatory professional training days a year. The focus of this training had changed since our last inspection, with more attention to the professional development of staff that related specifically to safe detention, and a range of other topics on custody.
- I.9** The force had a clear strategic commitment to preventing the entry of children and vulnerable persons into the criminal justice system and their diversion away from custody. This was clearly understood by all the officers we met during the inspection.
- I.10** There was little strategic oversight of the provision of health care, resulting in an inconsistent approach. Some suites had 24-hour health care cover but others relied on a rota of on-call doctors to provide the service. This led to some long waiting times and an inequitable service to detainees. The force had a limited understanding of the impact of the service for detainees. (See cause of concern and recommendation S31.)

Area for improvement

- I.11** **The force should ensure it has sufficient and sustainable staffing arrangements to deliver safe detention across its custody suites.**

Accountability

- I.12** The collation and monitoring of performance data on custody were generally good and most areas of performance were well understood. However, the data were not comprehensive across all key activities. For example, there were no data about voluntary attendance⁶ to understand if this provided an effective alternative to custody.
- I.13** There was generally good compliance with the Police and Criminal Evidence Act (PACE) and its codes of practice. There was some non-compliance - for example, detainees were not always told that there had been a review of their detention while they were asleep (contrary to section 15.7, code C; see area for improvement 3.51) and intoxicated detainees were not given information about their rights and entitlements when they were sufficiently fit to understand this (contrary to section 1.8, code C; see area for improvement 3.43). However, the position was generally better than we have seen in other forces recently inspected.
- I.14** The force collated data on use of force incidents within its custody suites, and was able to provide the datasets required for the Home Office annual data return, as recommended by the National Police Chiefs Council (NPCC). However, the governance and oversight of such incidents were not adequate, and the force did not have appropriate mechanisms to assure itself, the Mayor's Office for Policing and Crime (MOPAC) and the public that the use of force in detention and custody was safe and proportionate. While there was some evidence

⁶ Where suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

of quality assurance, this was not comprehensive enough and there was little cross-reference to CCTV footage of incidents. The force's scrutiny of such incidents was not, therefore, sufficiently robust to recognise any potential issues, and was not as good as at our previous inspection (see paragraph 4.8 and recommendation S30).

- I.15** Overall, quality assurance was limited. There was some sampling of custody records, which allowed some themes to be identified, but this was not sufficiently comprehensive. However, the force had a very effective process for reporting adverse incidents. All incidents were recorded as 'successful interventions' in averting them and reported to the force's strategic health and safety board. Learning from adverse incidents and near-misses was shared with staff, and used to improve organisational learning and inform training.
- I.16** While the force collated specific data on diversity in relation to custody, it was unclear how this was used to inform strategic learning or service improvement. There were no specific action plans or monitoring arrangements for custody. It was not clear how the force could demonstrate how it met the public sector equality duty for custody and that it treated all detainees fairly and equitably.
- I.17** The force was open to external scrutiny and responded positively to any issues raised by the Independent Custody Visitors (ICV) scheme. Regular meetings took place between the force and the scheme to facilitate this.
- I.18** There had been two deaths in custody since our last inspection, both of which were still being investigated by the Independent Office for Police Conduct (IOPC), and so it was inappropriate for our inspection to comment on these.

Area for improvement

- I.19** **The force should monitor data on diversity to ensure outcomes for detainees are fair, and be able to demonstrate that its custody practices meet the public sector equality duty.**

Partnerships

- I.20** The force showed a commitment to partnership working but the arrangements to deliver effective joint working in some key areas were underdeveloped. There had been some progress in the provision of alternative appropriate accommodation for children, but there was still no secure accommodation available across London. Most children charged and refused bail continued to remain in custody overnight.
- I.21** Similarly, the force had progressed work with partners to improve the provision of appropriate adult (AA) services and was addressing weaknesses identified in our previous inspections. However, this had not yet resulted in all children and vulnerable adults receiving support promptly and effectively.
- I.22** The force had continued to make significant improvements in provision for detainees with mental ill health. In 2018 to date, there had been only one instance of the use of custody as a place of safety under section 136 of the Mental Health Act (see footnote 2). While this area was not directly the responsibility of the custody detention command, there was effective representation at governance meetings, which had contributed to the significant improvement made.

- I.23** The force had engaged with partner agencies and charities to develop schemes to divert detainees away from custody and prevent reoffending. At some suites, a 'Divert' scheme had been developed to support 18-25-year-olds, for example, to access employment or housing and involving them in activities such as football. There was also work with the Prince's Trust to help young people access schemes and activities. Projects to divert children were also being developed, but currently mainly relied on referrals to youth offending teams (YOTs) for intervention work.

Section 2. 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

- 2.1 Frontline officers had a good understanding of vulnerability, and they cited factors for detainees, such as mental health, age and alcohol/drug abuse, as well as the circumstances that can put any individual at risk or in need of help. All children were regarded as vulnerable because of their age.
- 2.2 There were guidelines to help officers assess vulnerability and most had received training, although they felt there was an over-reliance on e-learning and presentations rather than more beneficial interactive sessions. Officers were clearly confident in assessing vulnerability and took account of this as a key factor when deciding whether it was appropriate to arrest an individual.
- 2.3 There was inconsistent and limited information provided by the call centres, which dealt with calls from the public, to help inform officer decision-making at the scene of an incident; this had not improved since our last inspection. In general, only basic information was provided and requests for further information were often not met. Frontline officers had hand-held tablets to access information directly, but they said these were not always practical when involved at an incident. Some officers could not access all the systems available, including the police national computer (PNC).
- 2.4 Information from partner agencies was also limited, especially in relation to people with mental ill health. The call centres supplied little information, and officers relied on accessing information direct from mental health teams. The arrangements for this, and the subsequent support offered, varied across London. Mental health services were expected to assist frontline police officers in deciding whether an individual should be detained under section 136 of the Mental Health Act 1983 (see footnote 2) but this did not always happen. Officers were often left to use their own judgement when making these decisions.
- 2.5 Officers told us they never took section 136 detainees to custody as a place of safety. However, they spent considerable time with detainees in police cars or at the scene of an incident waiting for a health-based place of safety to be found. Although the ambulance service should transport section 136 detainees, officers used their police cars instead to avoid further delays.
- 2.6 There was also little support to help officers deal with individuals who had committed offences but had mental ill health. Officers received limited advice from mental health professionals when deciding whether an individual was able to make their own decisions under the Mental Capacity Act 2005. They told us they were not always able to explore health-based options as an alternative to arrest, and often had no choice other than to arrest the individual for the offence committed so that they could get support for their mental ill health in custody.

- 2.7** Frontline officers had a good focus on diverting children away from custody and avoiding their entry into the criminal justice system where possible. In the three years to 30 June 2018, the number of children entering custody had reduced by 22% in the suites covered by this inspection.
- 2.8** Officers considered a range of alternatives to custody for children. These included speaking to parents about the child's behaviour or seeking informal agreement with victims, such as an apology. Voluntary interviews (see footnote 6) were also used, along with community resolutions⁷ where appropriate. However, officers saw safeguarding as their primary responsibility when dealing with children. The nature of some offences, with children involved in serious, violent and gang-related crime, meant that the risks to the child made arrest the best option to ensure that adequate safeguarding arrangements could be put in place.
- 2.9** Detainees were transported by police vans where possible. Where these were not available, or long waits were anticipated, police cars were used depending on the risk posed by detainees. There was an option to arrange accessible taxis for wheelchair users, if needed.

⁷ The resolution of a less serious offence or antisocial behaviour incident through informal agreement between the parties rather than progression through the criminal justice process.

Section 3. 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

- 3.1** The custody staff who we observed were respectful and empathetic in their interactions with detainees, and were usually mindful of their dignity in the custodial environment. We saw some examples of staff making extra efforts to establish a good rapport and understanding with detainees, especially when booking children into custody. Positively, we observed very few detainees walking barefoot or in socks around suites. This was better than we have seen in many recent inspections.
- 3.2** Except for Heathrow and Islington, the booking-in areas in the custody suites inspected offered particularly poor privacy for detainees to disclose sensitive and confidential information to custody staff. These areas were usually cramped, with multiple booking-in terminals sited close together and no screening or space between them, and other detainees, visitors or police officers regularly passed close by, further compromising privacy. During high levels of activity, noise in these environments made conversations difficult to hear. Few separate, private booking-in desks were available or appropriate: the discrete desk at Heathrow was used exclusively for bail returns; the one at Plumstead was next to the main desk and entry door and therefore redundant for this purpose. Some staff said they would offset this problem where possible. In a good example at Plumstead, a child charged with sex offences and his appropriate adult (AA) were taken to another room to be charged to protect their privacy. However, such practices were not consistent and we observed other cases where issues of privacy were not recognised or managed. In addition, telephones for detainees to speak to legal advisers, such as at Hounslow, were often placed in the main booking-in areas with no privacy from staff or other detainees.
- 3.3** Although many suites displayed notices to inform detainees they were being filmed and recorded in custody, this information was rarely reinforced verbally to detainees who may not have seen or understood these, such as non-English speakers. Although all cell toilets were suitably obscured on monitoring screens, so that custody staff could not see them in use, detainees placed into CCTV cells were not routinely informed of this, which could discourage them from using these facilities. CCTV monitoring screens were, however, positioned appropriately and out of sight of detainees.

Area for improvement

- 3.4** **Custody staff should protect detainees' privacy wherever possible, particularly at booking-in desks, and detainees should be told they are being recorded while in custody.**

Meeting diverse and individual needs

- 3.5** Detainees who we observed being booked into custody were consistently asked to self-define their ethnicity, which was appropriate. However, it was not clear how or whether this information was subsequently used, including in monitoring trends in the force's custody throughput and practices, or assessing fair and equitable treatment of all detainees (see area for improvement 1.19).
- 3.6** Custody staff demonstrated a generally good awareness and understanding of how they would identify and manage the individual and diverse needs of those who came into custody, such as how to address and search transgender detainees. However, their approach often derived from their own experience rather than any specific training. Some staff had received relevant training, including classroom-based inputs on women detainees' needs in custody, mental health and child sexual exploitation, but not all staff had received these or had done so some time ago.
- 3.7** For detainees with mental health needs, custody staff used the professional expertise and advice provided by the mental health liaison and diversion nurses available in most suites to help them understand or manage some detainees' particular needs.
- 3.8** Religious worship provision across the suites was inconsistent and did not always include artefacts, such as prayer books for Hindu or Jewish detainees, but those available were generally stored respectfully. Custody staff had received little training on these subjects with no access to (or knowledge of) relevant guidance to help them understand their context and implications for detainees in custody. However, some religious worship needs for detainees were addressed, such as the promotion and publication of Ramadan worship periods for Muslim detainees, and local arrangements in several suites to provide kosher food to Jewish detainees. Religious dietary requirements were covered with detainees being booked into custody as part of the standard risk assessment, but they were not asked about their wider faith and worship needs, which showed a lack of awareness of the importance of these matters to some detainees.
- 3.9** Arrangements for detainees with mobility impairment were largely poor and inadequate. With the exception of Heathrow, none of the suites were suitable environments, with few wheelchairs, extra-thick support mattresses, step-free access routes and showers, or adapted cells with height-adjusted call bells. In our talks with custody staff, we were not assured that detainees with such needs would be directed to a more suitable custody suite in the first instance. We were told of one case at Charing Cross in which, after waiting some time, a disabled detainee was transferred to another suite when staff recognised their disability needs. These issues had not been recorded or flagged by arresting officers or call centre staff, which resulted in the detainee spending a long time in an unsuitable custodial environment. However, most suites had coloured band markings in cells to help visually impaired detainees, and a few suites held a Braille version of the rights and entitlements information for detainees or other general reading materials. Hearing loops to assist staff interact with hearing-affected detainees were either not available or staff did not know how to use them; staff generally relied on using sign language interpreters.
- 3.10** The specific needs of women detainees were not met consistently or sufficiently. They did not always receive offers to speak privately with a female member of staff to discuss gender-specific or private matters, and some shift teams had no female members to facilitate this. Information sheets setting out female detainees' specific rights and entitlements were available at some but not all suites, and were not always handed out. Stocks of sanitary items were not sufficient across all the suites, with some suites holding only one type of product and limited sizes. These items were not always offered, even though this was covered in a specific question during each detainee's risk assessment; some staff told us that some male

custody staff were not comfortable raising such issues. This was a failure to look after the care needs of females in custody.

- 3.11** The arrangements for communicating with foreign national detainees were generally good. All suites had dual-handset telephones to access professional telephone interpreting services. We were told that these generally worked well, barring occasional comprehension difficulties with some interpreters. Some suites, such as Plumstead, Charing Cross and others, had video conferencing facilities to enable interpreters to take part during interviews more quickly. Staff said this was a valuable resource, although interpreters were also usually able to attend suites quickly given their central locations. Legal rights and entitlements materials were available in a range of languages and printed off as and where required.

Area for improvement

- 3.12** **The force should ensure that detainees' individual and diverse needs are appropriately and consistently met. In particular by:**
- **providing relevant training for all custody staff to identify the individual needs of detainees across all protected characteristics;**
 - **having facilities suitable for mobility-affected detainees in all suites or, where possible, directing these detainees to an appropriate alternative environment at the first point of contact;**
 - **providing improved support for female detainees, including offering them the opportunity to speak privately with a female member of staff and by routinely offering them access to a suitable range of sanitary items.**

Risk assessments

- 3.13** Detainees were not always booked into custody promptly (see paragraph 3.26) and some were made to wait outside police stations in vehicles. There was no evidence of triage to identify vulnerable detainees quickly or prioritise them for booking in.
- 3.14** Custody staff focused appropriately on identifying risk. They interacted well with detainees to complete standard risk assessments, responded to individual need, and asked relevant supplementary and probing questions. There was routine cross-referencing to police national computer (PNC) warning markers and historical information held on the custody record system to inform risk assessments further.
- 3.15** Some custody sergeants gave detainees generic support leaflets, usually issued on release, during the booking-in process (see paragraph 5.2). This was to give detainees an opportunity while in custody to consider engagement with any community support agencies; if detainees chose to, custody staff facilitated referrals to these agencies on their behalf, which was innovative.
- 3.16** Initial care plans did not always set observations at a level commensurate with the risks presented by the detainee. We found several instances in our case audits and our observations where 30-minute checks with rousals were not set for intoxicated detainees (as in *Authorised Professional Practice*) when there was clear evidence of intoxication. This posed a risk to some detainees. In general, observation levels were reviewed regularly, and when they were reduced or increased there was sufficient justification for this. The frequency of checks on detainees was mostly adhered to, but these checks were not always documented sufficiently and some timings were not recorded. Despite our concerns about the setting of observation levels involving rousals, where rousals for intoxicated detainees were identified, staff conducted these checks competently and documented them well. Posters on cell doors

directed at officers promoted the practice and importance of rousing. However, the role of carrying out observation checks was not always allocated to a single DDO and was often rotated between different staff. This made it harder for DDOs to build rapport with detainees and potentially identify any behaviour or mood changes that could affect their safety. This posed significant risks, particularly to detainees who were intoxicated.

- 3.17** It was positive that all custody staff carried anti-ligature knives. Officers conducting close proximity watches (known as constant supervision in Met detention, where the detainee is physically supervised in close proximity to enable immediate intervention to take place if necessary) with detainees were well briefed by custody sergeants, although they sometimes remained in position for too long without any breaks. In our case audits and observations, we found that some close proximity watches took place through the cell door hatch rather than with the cell door open as is usually expected, without sufficient justification.
- 3.18** The allocation of cell keys was not always managed well enough and there was often insufficient oversight by custody sergeants. In all the suites we saw non-custody staff routinely handed cell keys to lodge or move detainees between the cells and interview rooms, which diminished custody staff control in the custody suite and presented risks.
- 3.19** Staff were generally confident and competent in managing the risks associated with suicide and self-harm. Footwear or shoelaces, clothing with cords and personal possessions such as spectacles were generally only removed from detainees following an individual risk assessment. Staff understood that leaving a detainee in their own clothes could prevent an escalation of risky behaviour. Positively, anti-rip clothing was not used anywhere across the force, and the risk of self-harm was managed in ways to avoid confrontation and minimise distress to detainees.
- 3.20** When detainees pressed their cell call bells they were not always answered promptly; we observed some delays of between four and 10 minutes. Some DDOs muted call bells without this being authorised by a custody sergeant or documented in the custody record. These practices posed potential risks to detainees who required assistance.
- 3.21** The quality of staff shift handovers varied. They did not always include all relevant staff, and were generally done between one of the incoming sergeants and one of the outgoing sergeants, with a variety of different handover sheets used as a briefing document. There was no collective handover between the whole incoming and outgoing custody staff shift to ensure all aspects of the detainees could be fully discussed. We saw some custody sergeants visiting the detainees in their care at the start of a new shift, but some made no effort to introduce themselves to detainees or have any meaningful interaction with them. At Charing Cross, the practice of four or five staff entering a detainee's cell as part of the 'walk around', to check both on the condition of the cell in addition to the detainee's condition, was oppressive and carried out with no consideration for the well-being of the detainee (see also paragraph 4.4). We saw one woman detainee who was visibly distressed at this practice, and this particular approach should cease. In most cases, the sergeant who visited the detainees later had a collective handover with all incoming staff, but there were inconsistencies in how these briefings were conducted.

Area for improvement

- 3.22** The force should strengthen its approach to managing detainee risks, including by:
- ensuring all detainees who are intoxicated are placed on rousal checks;
 - answering cell bells promptly, only muting them with good rationale and proper authority, for the shortest time necessary, and subject to regular review;
 - having a consistent approach to shift handovers, ensuring that they involve all custody staff, share comprehensive information about detainees and include custody sergeants visiting detainees to check on their welfare.

Individual legal rights

- 3.23** Arresting officers clearly explained the circumstances and grounds for arrest in the detainee's presence when they were booked into custody. In general, officers showed a good understanding of the necessity for arrest as required by the Police and Criminal Evidence Act (PACE) code G and complied with this. However, we observed that this was not always adequately explained to the detainee or fully recorded on the custody record.
- 3.24** Custody sergeants treated detainees with dignity and respect, generally took great care to explain why their detention was being authorised, and further checked with them that they understood what was being said. In all the cases we observed, detention was authorised appropriately, but it was clear that custody sergeants would refuse detention if the circumstances warranted this, and we saw some examples of this.
- 3.25** In suites where DDOs booked detainees into custody, sergeants authorised the detention and provided adequate oversight of the process; this maintained their responsibility in caring for the detainee and ensured they understood their rights.
- 3.26** Other than in exceptional circumstances, we expect detention to be authorised no more than a few minutes after the detainee arrives at the custody suite. We found that waiting times between detainees arriving at the custody suites and detention being authorised were generally good. Our analysis of custody records showed that the average waiting time between arrival and authorisation was 17 minutes, and data provided by the force indicated that adult detainees waited on average 15 minutes between arrival and authorisation, and children 18 minutes. However, officers told us, and we both observed and found in custody records, that some detainees waited an hour or more to be booked in, particularly during custody staff shift changes when handover of detainees took place.
- 3.27** Cases were not always progressed promptly, and delays in allocating and carrying out investigations extended the time some detainees spent in custody. Custody staff told us they spent much time chasing up investigators and supervisors about the progress of investigations. We saw one custody sergeant who made six attempts over an eight-hour period and spoke to three different supervisors to obtain an update on the progress of an investigation. In several instances, delays in allocating and conducting investigations into the most basic of cases led to detainees kept in custody for much longer than necessary. On one occasion, a detainee was bailed from custody after 19 hours because no one had been allocated to deal with the investigation.
- 3.28** Delays in the arrival of appropriate adults (AAs) also contributed to extending detention time (see paragraphs 4.28–4.29 and area for improvement 4.44). The lack of a 24-hour service across most suites meant that some detainees were kept overnight until an AA could

be called the following morning. However, access to interpreters was generally good and could be arranged promptly.

- 3.29** Alternatives to custody were available in the form of voluntary attendance (see footnote 6), fixed penalty notices and community resolutions (see footnote 7). The force could not provide data on use of voluntary attendance so it was not possible to assess how well this was used as an alternative to custody.
- 3.30** The number of immigration detainees brought into custody had decreased by 33% from 1,958 to 1,303 in the three years to 30 June 2018. Custody sergeants said that they had good working relationships with immigration officials, who were embedded in many custody suites. Data provided by the force showed that foreign nationals detained in police custody under an IS91 authority to detain spent an average of seven hours 50 minutes there before they were conveyed to alternative accommodation, which compared favourably with other forces we have inspected.
- 3.31** Custody sergeants explained the three main rights (to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice) to detainees during booking-in. Most detainees were given the current rights and entitlements notice (May 2017) to read while in custody. However, the print on the notice was very small and extremely difficult to read, particularly for detainees who may be visually impaired.
- 3.32** Where a detainee declined their right to free legal advice, custody sergeants explored this decision with them and recorded their reasons on the custody record.
- 3.33** We found occasions where it was decided that a detainee was unfit, usually because of intoxication, to be given their rights and entitlements when their detention was authorised. However, these were not always subsequently given even though the detainee was fit to receive them, which was contrary to PACE code C, section 1.8.
- 3.34** The current PACE code C booklets (February 2017) were not readily available at all the custody suites. Custody staff regularly told us that if a detainee requested a copy they would print off one for them from the internet. Given the size of the booklet (about 85 pages), this was not a practical solution, and not having them readily available for detainees in the suites was contrary to PACE code C, section 1.2.
- 3.35** Multilingual posters advertising detainees' right to free legal advice were displayed prominently in most custody suites, as required by PACE code C, section 6.3.
- 3.36** Not all the custody staff we spoke to were aware of or understood the requirements of PACE code C, annex M on the provision of translated detention documents. Most were unsure where the documents could be found and printed off if the documents were required by a detainee.
- 3.37** We saw custody sergeants authorising the taking of DNA samples from detainees appropriately. Once taken, DNA samples were mostly collected from custody suites promptly. However, the required audit trails for DNA samples were not sufficiently robust to ensure the integrity of the sample, and not all DNA fridges were locked.

Areas for improvement

- 3.38** The force should consistently comply with all aspects of the PACE codes of practice. In particular by:
- ensuring that detainees unfit to receive their rights and entitlements when they are booked into custody receive these as soon as they are fit to;
 - ensuring sufficient copies of the latest version of PACE code C are readily available for detainees in all custody suites;
 - making custody staff aware of the availability and importance of translated documents for detainees and provide them in line with PACE code C, annex M.
- 3.39** The force should minimise delays in progressing investigations so that detainees spend no longer than necessary in custody.

PACE reviews

- 3.40** The standard of PACE reviews we observed was generally good. This was a significant improvement since our previous inspection. Reviewing officers treated detainees with respect and checked that they understood what they were told. We saw reviewing officers explaining their role and covering the detained person's rights and entitlements. They also covered aspects of the detainee's health and welfare, and updated them on the progress of the investigation. Reviews were recorded accurately on the custody record.
- 3.41** Custody inspectors we spoke to recognised the importance of conducting reviews of detention on time and in person wherever possible. Our custody record analysis found that the majority of reviews of detention were held in person with only a few done by telephone. In our custody record analysis, the average time between detention being authorised and the first review was five hours, but some reviews were too early - on one occasion 77 minutes after detention had been authorised. Inspectors were not on duty between 5am and 7am, which meant that any reviews due between these times would either be early or late.
- 3.42** We found that when detention was reviewed while the detainee was asleep, they were not always told that the review had taken place once they were awake. This was contrary to PACE code C, section 15.7.
- 3.43** Acting inspectors carried out some PACE reviews when substantive inspectors were not available. Although the status of the acting inspector carrying out the review was recorded to show they had sufficient authority, the ad hoc nature of these arrangements, and the reliance on them, meant that some officers frequently 'acted up' for just a day at a time. This diminished the importance that should be attached to this role and was not the intention underpinning section 107 of PACE, which sets out who can perform the role of a reviewing officer.

Area for improvement

- 3.44** The approach to PACE reviews of detention should be improved. In particular:
- the force must consistently comply with section 15.7, code C of PACE by reminding detainees that a review of detention has taken place while they were asleep;
 - reviews of detention should only be carried out by substantive inspectors or sergeants who are properly authorised by the force to act in the rank of inspector and perform the role as reviewing officer.
- 3.45** There was guidance on the use of bail that officers followed. Bail was authorised appropriately and in accordance with the applicable bail periods set out in legislation. These were adhered to and proportionate to the complexity of investigations. Conditions imposed were appropriate to prevent detainees reoffending and to safeguard victims. The force had focused on using bail effectively to safeguard vulnerable victims, and had recently increased its use from 6% to 10% of all detainees released from custody.
- 3.46** Officers made effective use of release under investigation (RUI) from custody. Force information showed that at the time of our inspection there were 7,700 suspects force-wide released under investigation subject to live investigations. However, there were over 33,000 open RUI records in the custody system from across the force that needed checking and closing; the force had an action plan to address this.
- 3.47** Custody sergeants routinely handed notices to detainees about their RUI status but did not always explain verbally what this meant, and any potential consequences should they interfere with the course of justice. This led to the risk that detainees did not understand the significance of RUI and what was expected of them.

Area for improvement

- 3.48** When custody sergeants hand notices to suspects being released under investigation they should explain what it means and the consequences should they interfere with the course of justice.

Complaints

- 3.49** There was little emphasis on explaining the importance of detainees' right to complain, other than a small paragraph on the rights and entitlement leaflet. No posters were displayed in any of the custody suites or reception desks informing detainees of how they could make a complaint, and there were no leaflets available.
- 3.50** Custody staff informed us that they would speak with the detainee and deal with any minor issues there and then. For more serious complaints, most staff said they would pass these on to the custody support inspector to deal with and record the complaint on the custody record. However, in some suites we were told that complaints would not be taken and the detainee was told to ring 101 (the police national non-emergency number) or complain at the front enquiry office after release. There were no separate processes for complaints about the police and those relating to clinical care while in custody (see also paragraph 4.49). There had been no improvement in the approach to complaints since our last inspection.

Area for improvement

- 3.51 Complaints procedures should be adequately promoted in all custody suites. When complaints are made they should be dealt with in a consistent way and, where possible, while the detainee is in custody.**

Section 4. 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

- 4.1 The custody estate was mostly old and dated, but conditions and cleanliness were generally good. There was very little in-cell graffiti. All cells had natural light and the temperature was suitable, but very few had air conditioning. When cells had biological hazards that required a deep clean, these were dealt with promptly and efficiently by an external contractor.
- 4.2 The custody estate lacked facilities that we would expect in suites. Most had no in-cell sinks, no discrete booking-in desks or privacy screening at them, no exercise yards, no accessible toilets or showers, few adaptations for detainees with disabilities and no cells with glass panels in the doors. Not all cells were covered by CCTV, and the coverage in some suites was poor with blind spots in communal areas.
- 4.3 The cell call bells we tested were functioning but during the inspection we observed they were not always answered promptly, which presented a risk (see paragraph 3.20 and area for improvement 3.22). In many suites, the call bell monitors only identified the cell corridor where it had been activated and not the actual cell, making it unclear who was seeking assistance.
- 4.4 Designated detention officers (DDOs) made routine daily checks of the physical environment using a comprehensive checklist, which included all cells and communal areas, but we found variance in the way these checks were carried out (see paragraph 3.21). Any damage or faults were recorded locally and reported to a central department. Most minor faults were responded to promptly but staff told us, and we observed, that some cells had been out of use for several weeks waiting repairs. We identified many potential ligature points in cells and communal areas in most of the suites. We provided the force with a comprehensive report to illustrate the range of potential ligature points we found, and they took action straightaway to start remedying these.
- 4.5 Custody staff had limited awareness of the fire evacuation procedures and not all had been involved in a fire drill in the past 18 months, which contravened legal requirements. Fire evacuation routes were not readily identifiable and most suites did not display any fire evacuation plans, which was a risk to both detainees and staff. There was a further risk as many staff worked overtime in suites they were not familiar with.
- 4.6 Custody staff received mandatory first aid training and could readily access standard first aid boxes and automated external defibrillators, which were routinely checked. All suites had appropriate resuscitation equipment that could be used by the custody nurse practitioners and forensic medical examiners trained in providing life support in medical emergencies.

Area for improvement

4.7 The force should ensure that all custody staff take part in an annual fire drill.

Safety: use of force

- 4.8** Although the force collected data on the use of force in custody, we found some under-recording of incidents that undermined their reliability. The governance and oversight of use of force were inadequate. Staff involved in the use of force against detainees did not always complete the required use of force forms. In the incidents for which we requested documentation, there were either no use of force documents or not the full number required. The recording of information in custody records did not always make it clear that force had been used and, when it did, the entries were sometimes inaccurate and did not justify the use (see cause of concern and recommendation S30).
- 4.9** Due to the introduction of a new human resources system in February 2018, the force was unable to supply any data on whether staff had completed the annual officer safety training. However, all the custody staff we spoke with said they were in date with their training or that this was scheduled to take place soon. Most custody staff carried personal safety equipment, including batons (sergeants only) and handcuffs, which we do not routinely see in controlled custody environments.
- 4.10** Custody staff generally dealt patiently and sensitively with some challenging detainees. The force promoted a clear focus on de-escalation, and staff told us they would only use force as a last resort following negotiations with detainees to de-escalate situations where possible.
- 4.11** Through our custody record analysis, case audits and observations we identified 24 recent incidents involving the use of force that we reviewed in depth, including cross-referencing against CCTV footage. Half of the incidents were managed well overall. We found a range of learning points in the remainder. Concerns from the CCTV footage included the application and length of time detainees remained in a 'spit and bite' guard (spit hood), the conduct of strip searches and some poor use of techniques. We referred two cases to the force for full review due to what appeared to be the lack of proportionality of force used (see cause of concern and recommendation S30).
- 4.12** We were told that inspectors reviewed a few 'risk' cases each month that might have involved the use of force, which they cross-referenced to CCTV records. There was, however, no specific oversight of the use of force to assure managers that the force used in custody had been proportionate to the risks/threat posed or to identify any learning points.
- 4.13** Detainees often arrived in custody in handcuffs. We saw cases where handcuffs remained in place for too long on compliant detainees. This was disproportionate to the threat posed in the controlled custody environment.
- 4.14** In the previous 12 months, 10,278 detainees in the suites inspected (16%) had been subject to a strip search in custody, which was higher than we normally see. This included a high proportion of children and a disproportionately higher number of black and minority ethnic (BME) detainees when compared against the overall throughput for custody during that time (BME detainees accounted for 25% of the throughput and 51% of those strip-searched). Not all the strip searches that we saw during the inspection were warranted or properly justified. They were mainly conducted in search rooms. Where these were not available, searches generally took place in a cell but, to maintain privacy, staff ensured that CCTV monitors were switched off.

Area for improvement

- 4.15** Strip searches should only take place when there are reasonable grounds to suspect a detainee may have concealed an article that they would not be allowed to keep. The grounds and justification for such a search should be fully recorded on the detainee's custody record.

Detainee care

- 4.16** Detainees told us that they were generally treated well during their stay in custody. They were offered food and drink throughout the day and not just at specific meal times. In our custody record analysis, 97% of detainees had been offered something to eat; in some suites it was 100%. There was a full range of microwaveable food in all suites, including vegetarian, vegan and halal options. Kosher food was provided at Heathrow, and in other suites there were arrangements for meals to be brought in by external providers, although this was not often required. Detainees who were particularly hungry, for example those who had been homeless, were provided with additional meals.
- 4.17** A range of alternative clothing was available, including jogging bottoms, sweatshirts and plimsolls, although most detainees remained in their own clothes. Detainees in all cells were given plastic mattresses and pillows. Blankets were generally provided on request, as were other items of basic care, such as toilet paper and sanitary items; these were not routinely offered by custody staff and detainees were generally expected to request them. (See also area for improvement 3.12.) The practice of having to routinely request toilet paper was undignified and contrary to 5.3 of *Detainee Care in Detention and Custody in Authorised Professional Practice*, which states that the default position should be that detainees are supplied with toilet paper unless there is evidence that they may try to harm themselves.
- 4.18** As few suites had in-cell sinks detainees had to ask to wash their hands. This was insanitary. Detainees generally also had to ask to use a shower. Custody staff told us that they often did not have sufficient staff to prioritise detainee showers. In our observations, few detainees were informed of the availability of showers or that they could wash their hands.
- 4.19** A mixed range of reading materials was available, which had mainly been donated. Some suites, but not all, had newspapers and magazines and easy-to-read books; there was little foreign language material. The reading materials were also not routinely offered and we observed few detainees with anything to read.
- 4.20** There were limited facilities for detainees to access fresh air or exercise. Most suites had no suitable outside areas, including Heathrow, where there was no outside space incorporated into the design. The 'exercise rooms' provided there were oppressive and not suitable. As with other aspects of detainee care, exercise was not routinely offered and had to be requested by the detainee.
- 4.21** The culture of expecting detainees to request access to basic facilities and amenities relied on them knowing that they could do so. It was inadequate that detainees were not offered access to all aspects of their care routinely on arrival or during long stays in custody.

Area for improvement

- 4.22** Detainee care should be improved. In particular, detainees should be routinely offered toilet paper, access to handwashing facilities and, those held overnight, a shower. There should be a suitable range of reading materials that are actively offered, and all custody suites should have exercise facilities of an appropriate size and in a suitable location to provide detainees with access to fresh air and exercise.

Safeguarding

- 4.23** The force's clear priority for safeguarding children and vulnerable adults was well understood and reflected operationally. Although some of the concerns raised in our 2017 inspection remained, several areas in relation to safeguarding and the care shown to children had improved.
- 4.24** All the officers we spoke to were alert to recognising and dealing with safeguarding concerns. Safeguarding training had been rolled out for all officers across the force and there had been some specific training for custody, mainly aimed at inspectors who were then responsible for discussing issues with their staff. Despite this, not all the custody staff we spoke to felt well supported by training, and some told us there was a reliance on emails and e-learning to spread awareness.
- 4.25** There was a safeguarding strategy for custody to provide an operational framework for staff. Some custody teams had designated 'safeguarding champions' to promote safeguarding issues and this approach was being rolled out across all the custody suites. The champions received additional training.
- 4.26** There were clear guidelines for staff to ensure they passed on safeguarding concerns to the appropriate agencies to deal with. It was mainly arresting or investigating officers who made the safeguarding referrals, with custody sergeants responsible for ensuring that officers took further actions should any concerns arise while detainees were in custody.
- 4.27** Custody staff could look at any safeguarding referrals made, but the custody records indicated little recording of these or the concerns raised. It was, therefore, not clear how this information fed into risk assessments and care for the detainee while in custody. However, there was a focus on making sure that vulnerable adults and children were released safely from custody with arrangements for them to get home, and in the case of children to the care of a responsible adult (see paragraph 5.3).
- 4.28** Children and vulnerable detainees did not always receive early support from appropriate adults (AAs) to help them understand their rights and entitlements, and custody processes. The arrangements were inconsistent, and outcomes were poor for some detainees.
- 4.29** In general, custody sergeants tried to contact AAs early on in detention, especially for children. Our analysis of custody records showed that for children, calls for AAs were made within an average of one hour and 38 minutes from their arrival in custody. In some cases this led to prompt attendance. In others, difficulties in contacting AAs or their ability or willingness to attend early led to some children waiting a long time before an AA arrived to support them. Our analysis showed waiting times varied between 4 and 16 hours.
- 4.30** Most custody sergeants were confident in deciding whether a vulnerable adult required an AA, and often obtained advice from their health care colleagues in custody. However, calls to AAs to support vulnerable adults were not always made quickly, and AAs were not always

called when there was evidence that this should have been considered. In some cases, vulnerable adults were fingerprinted or had other custody processes completed without an AA present.

- 4.31** Family, friends or care workers were called in the first instance. Where they were not available, custody sergeants had to rely on local authority children's social services or a range of schemes for vulnerable adults. This resulted in an inconsistent service for both children and vulnerable adults across the different suites. Although there were some exceptions, AAs could or would not attend overnight and often were only prepared to come for the time of the interview with the detainee, which could be several hours into their detention.
- 4.32** There was little monitoring by the force to assess how long detainees waited before receiving support from AAs, although this information had started to be gathered. Although most of the custody sergeants understood their responsibility to secure an AA as soon as practicable, it was not always clear from the custody records that they had done this. It was often left to investigating officers to arrange an AA to coincide with the time for the detainee interview, with little oversight from custody sergeants to minimise any delays.
- 4.33** The force was aware of the shortcomings in AA services and had been working with partners to improve provision across London. Joint funding had been agreed in principle to deliver a more standardised and consistent service.
- 4.34** There was guidance in the custody suites to help AAs not familiar with the role to understand what was expected of them. Custody sergeants told us that they also explained this verbally.
- 4.35** Custody staff engaged with children well and showed them some good care. They were offered food and drinks regularly, and telephone calls to family members or friends were facilitated. In one case we reviewed, a mother stayed with her son as he was at risk of self-harm, as this was deemed to be better for him than to be watched by officers. Girls were generally allocated a female member of staff, in line with the Children and Young Persons Act 1933, although this was not always recorded on the custody record.
- 4.36** Inspector reviews of detention were mainly face to face and included checks on the child's welfare and, for example, whether an AA had been arranged. Some suites had easy-read leaflets but some had to be printed off, which was not practical, and they were not always given out.
- 4.37** Other than trying to place children in the cells near to the custody desk, designated as juvenile detention rooms, there was little attention to keeping them away from adult detainees when they were booked in, or giving them priority in the holding areas. We raised this concern in our previous inspection but little action had been taken. The force policy that children should be seen by the custody mental health nurses did not always happen in practice.
- 4.38** There was a focus on minimising detention times for children and avoiding their overnight detention, with bail used where appropriate to achieve this. We looked at some cases that had been progressed quickly to reach a decision so the child could be released, but others where there had been delay. Delays in carrying out the investigation, difficulties in obtaining AAs, and in some cases the need for a care home placement by children's social services extended the time some children spent in custody (see also paragraph 3.28 and area for improvement 3.39).
- 4.39** The force actively monitored children in custody. Information on every child held in custody at 8.30am was collated and discussed at the daily custody meeting, and broken down by suite. Inspectors were expected to check that the children in the suites they were

responsible for were dealt with effectively and that their time in custody was minimised. This information was not available on weekends but there were plans to introduce this.

- 4.40** Children charged and refused bail were also monitored. In these cases, local authorities have a statutory duty to secure alternative accommodation so that the child does not remain in custody. Where children were not moved, custody sergeants completed juvenile detention certificates for the courts explaining why the child had remained in custody. These certificates were reviewed regularly to ensure they were completed correctly, and to identify common themes and share any learning. They were also shared with local authority partners to support partnership discussions about where improvements were needed.
- 4.41** There was a 'children in custody' strategy group where the force and its partners considered a range of information, including the provision of alternative accommodation. Few local authorities across London had signed up to the Home Office concordat on children in custody. However, joint working had started between the force and the local authorities to develop a London-wide children in custody protocol to agree consistent working practices and improve performance and monitoring.
- 4.42** There had been guidance and training to help custody sergeants determine whether secure or non-secure accommodation should be requested from the local authority when children were charged and refused bail. Most custody sergeants we spoke with had a good understanding of this. In practice, the nature of the offences committed by these children, many of whom were involved in gang-related and violent crime that necessitated the refusal of bail, meant that the risks they posed to others or themselves were significant enough to warrant secure accommodation; however, there was none available in London. Custody sergeants reported that the position in finding appropriate non-secure accommodation had started to improve.
- 4.43** Outcomes for children charged and refused bail remained poor, with few transferred from custody. Force data for the suites inspected for the 11 months to 31 May 2018 showed that 1,268 children were remanded after charge.⁸ There had been 335 requests for secure accommodation and 313 for non-secure that had not been met by the local authorities, and these children remained in custody when they should have been moved. Although an improvement from our previous inspection, only a total of 68 children were moved, with only two to secure accommodation.

Areas for improvement

- 4.44** **The force should ensure that children and vulnerable adults consistently receive early support from appropriate adults.**
- 4.45** **The force should continue to work with its partners to ensure that children charged and refused bail are moved from custody to alternative accommodation provided by the local authority.**

Governance of health care

- 4.46** Physical health care services were delivered by directly employed nurses and self-employed forensic medical examiners (FMEs) as part of the Metropolitan Police Forensic Healthcare Service. A health needs assessment from 2014 needed to be updated to reflect changing need. There was no governance structure to oversee and determine the strategic direction

⁸ Some of these children were detained on warrant or for breach of bail so there was no requirement to move them, and for others there was insufficient time before the court hearing for a transfer to take place.

of health provision, and no agreed performance measures - such as attendance linked to clinical or forensic priorities - to ensure detainee care was appropriate to need.

- 4.47** An improvement plan had been developed and the model agreed delivered a continuous nurse-led presence in suites, with high activity through custody nurse practitioners (CNPs) and peripatetic FMEs providing cover for two sites. This approach was being modified during the inspection, increasing the number of nurse-led embedded suites and broadening the range of FME cover to three suites. The absence of clinical performance data meant the rationale behind these decisions was not robust. We also found gaps in the medical rota, particularly at night. Nursing shifts also faced occasional shortfalls, which sometimes strained the service offered to detainees. During the inspection, we saw examples where detainees with clear health needs faced significant delays in being seen by a health professional. In our custody records analysis, the mean time between a health professional being called and their arrival was one hour 44 minutes, ranging from zero minutes to nine hours 24 minutes. The longest waits were in the areas covered by FMEs. Many custody staff said that if FMEs could not meet a request to see a detainee before the end of their shift they had to wait for the next available FME, which created clinical risk.
- 4.48** The absence of a force strategic oversight of the model and operational delivery of health care was a significant concern, particularly given the dichotomy of professional views about the model of health care delivery expressed by the most senior clinicians responsible for the service. (See cause of concern and recommendation S31.)
- 4.49** Nurse staffing levels and some aspects of clinical governance had improved since the last inspection. However, there were separate approaches to nursing and medical practice, whereas both professional functions should be considered in an integrated way that focuses on patient outcomes and experience. There was no confidential health complaints process (see also paragraph 3.50) or discrete clinical incident management reporting systems. Despite this, complaints were generally well managed and we saw evidence that lessons had been learned and shared with frontline staff, including custody staff.
- 4.50** Quality assurance was limited but we were told that additional resources had been commissioned to provide quality assurance of medical practice. There was initial competency-based training for all professionals, as well as ongoing individual nurse training and two professional development days a year for nurses - although many said these were difficult to attend. FMEs undertook all essential mandatory training and activity was monitored appropriately.
- 4.51** Clinical policies were readily accessible and covered most key areas. Clinical rooms were appropriate but there were no separate areas for forensic sampling. Cleaning arrangements were adequate, although some practices and fixtures did not comply fully with infection prevention standards. Equipment was appropriate, although many FMEs preferred to carry their own basic equipment between suites.

Area for improvement

- 4.52** **Clinical governance arrangements should encompass detainee outcomes and include provision of confidential health complaints, integrated clinical incidents systems, quality assurance of practice and regular audit of medicine storage and systems to ensure the safe reconciliation of medicine stocks. Detainees requiring an assessment by a forensic medical examiner should be seen within agreed response times, which should be monitored as part of clinical governance.**

Patient care

- 4.53** Custody staff referred detainees to health professionals appropriately, based on concerns observed or raised by the detainees. We saw mostly good working relationships and custody staff were largely positive about health care, particularly where services were embedded in the suite. All health professionals said that they prioritised detainee access based on clinical need and risk. In the sessions we observed, health professionals were mostly sensitive and responsive to the needs of detainees. They had access to telephone interpreting services where needed, including dual-telephone handsets in most suites. However, consultations were rarely confidential; treatment room doors were routinely propped open and DDOs stood within earshot, without consideration of individual risk.
- 4.54** CNPs completed an electronic custody health assessment plan for all detainees seen. All contacts and any key risk issues were summarised on the national police IT (NSPIS) custody record. The clinical records were reasonable although not routinely available to FMEs. FMEs completed handwritten records that they stored offsite, which did not comply with expected standards for information governance. NPSIS records included generic but potentially confidential clinical issues to ensure an appropriate handover of information to other clinicians. An electronic clinical records system, Excelicare, had been successfully piloted in one suite, which could address many of the concerns about record keeping and collection of clinical performance data.
- 4.55** Detainees on prescribed medication could generally access this in custody once reviewed by a health professional, and if appropriately labelled. Police attempted to retrieve medication from detainees' homes where appropriate. Medication administration and storage arrangements were safe. Detainees' individual medicines were stored mainly with their property, with medical instructions detailed in the custody records. Health practitioners could access the NHS summary record, which allowed them to view any detainees' current prescriptions, enabling effective continuity of treatment.
- 4.56** Detainees could receive symptomatic relief for withdrawal from alcohol and drugs, but such medicines were not routinely sent with detainees attending court. This created risks of medical complications, particularly for alcohol withdrawals, although detainees generally received such medicines in the morning before leaving for court. Nicotine replacement therapy was not routinely available. There was a policy to facilitate opiate substitution therapy for detainees on prescribed regimes of methadone or buprenorphine. Only FMEs could supervise administration of these drugs; given the problems identified in accessing an FME, facilitating treatment could be inconsistent.
- 4.57** In suites with a continuous health presence, nurses were responsible for ordering and checking stock in collaboration with custody staff. In other areas, custody sergeants had this responsibility. Stock was standardised and - although excessive - was based on clinical evidence and cost. However, general stock control and medicine reconciliation arrangements were inadequate. Controlled drugs were stored safely and checked daily, which ensured accountability, and discrepancies were investigated. A medicines management group had been established, which included input from a pharmacist, and all patient group directions (authorising appropriate health care professionals to supply and administer prescription-only medicine) were being reviewed at the time of the inspection.

Areas for improvement

- 4.58 Health care staff should see detainees in private, subject to an individual risk assessment.**
- 4.59 Medication due for administration while detainees are at court should be sent with them, and detainees who smoke should have prompt access to nicotine replacement therapy if clinically appropriate.**
- 4.60 An electronic clinical record system shared by custody nurse practitioners and forensic medical examiners should be established as a priority to ensure health care practice is in line with professional standards, the Data Protection Act and Caldicott guidelines on the confidentiality of personal health information.**

Substance misuse

- 4.61** Only Lewisham had direct access to a community-based substance misuse service that provided active support to adults with alcohol and/or drug issues. In all other suites, custody staff and other health professionals referred detainees with these needs to local community services. The absence of in-suite support was a gap in provision that limited prompt access to treatment for detainees who had identified need, or were held on suspicion of drug-related offending.
- 4.62** Despite this, target drug testing for trigger offences and referral into community treatment were provided in all suites. However, in some boroughs any ongoing attendance and engagement with treatment services was voluntary, which limited the effectiveness of this approach. Detainees leaving custody were given information about community drug and alcohol treatment services, but there was no immediate access to harm minimisation services and supplies.

Area for improvement

- 4.63 Detainees should receive prompt and consistent access to in-suite substance misuse services.**

Mental health

- 4.64** Most custody staff demonstrated good awareness about mental health and the impact it could have on detainees in custody. Initial training programmes for custody staff addressed this subject. Ongoing in-house programmes had included service users sharing their direct experience of custody, which was good practice.
- 4.65** All suites had input from mental health liaison and diversion practitioners. Six specialist trusts and providers delivered this input across the suites we inspected. The nature and range of the service varied between suites, with some areas providing regular dedicated support, including at weekends, and others sharing access with courts services or across suites. Most support was currently delivered on weekdays. The input was reasonable and valued by custody staff we spoke to, with clear evidence of partnership working. We were told that NHS commissioners had ringfenced further revenue to deliver more consistent and extended provision across all custody areas, which was a positive initiative that would improve support for detainees.

- 4.66** Custody staff referred detainees on the basis of their initial risk screening or observed presentation in custody. Detainees were seen promptly when practitioners were available in the suite, but out-of-hours access was more of a problem. Mental health practitioners had access to their own organisations' health records and collaborated closely with other trusts to learn if detainees were known to services and the support that was being provided. Detainees were actively supported and signposted to other agencies when appropriate, with some providers offering direct community follow up.
- 4.67** In the previous six months, an inspector had led significant improvements on information and data gathering of mental health need in custody. The information compiled was impressive and captured individual needs and response time for detainees, particularly those needing Mental Health Act assessments. This will enable the force to understand its activity and the needs of detainees better. Assessments for detention under the Mental Health Act were generally prompt but there were significant variations, and slippages, particularly out of hours. As a result, too many detainees experienced excessive delays, mainly due to shortages of professionals to undertake assessments, the absence of inpatient beds and delays in organising transport and transfers.
- 4.68** There were good joint working arrangements between the police and mental health services at local and borough levels. A strategic partnership board, involving each trust, provider and relevant local authority, worked to ensure detainee outcomes were effectively monitored and assessed. However, police involvement at this strategic group was more limited, which could mean that providers did not take sufficient account of policing priorities.
- 4.69** There were no street triage schemes providing specialist advice and assistance to help officers deal with people with mental ill health; this potentially limited the police's ability to assess risks and offer less restrictive support. It was positive that in 2018 to date, only one case was reported to us of a person being detained in any suites we inspected as a place of safety under section 136 of the Mental Health Act.

Area for improvement

- 4.70** **Detainees with acute mental health issues should receive prompt Mental Health Act assessments, and agreed transfers to hospital facilities should be carried out promptly.**

Good practice

- 4.71** *The in-house training programme for custody officers on mental health included service users and their direct experience of custody.*

Section 5. 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

- 5.1** There was not always a consistent focus on ensuring that all detainees were released safely. The lack of an enhanced risk assessment for high risk detainees was a weakness. Although we observed some very good quality assessments where custody sergeants clearly paid attention to securing a safe release for detainees, we also saw, to a lesser degree, some poor quality release arrangements. The recording of release arrangements was variable and some that we reviewed in our case audits reflected that there was little indication that identified risks were routinely addressed or mitigated before release. It was also often unclear how detainees, including the most vulnerable, were getting home.
- 5.2** All detainees were given a generic support leaflet with useful telephone numbers on their release (see also paragraph 3.15). However, not all custody sergeants fully explained the purpose of the leaflet or what the community support agencies could provide. Many custody sergeants were not aware that these leaflets were also available in several foreign languages for non-English speaking detainees.
- 5.3** Although sergeants generally enquired how detainees were getting home, travel warrants were not readily available and there was no access to petty cash to pay for transport if needed. We were not assured that all detainees were released safely as staff told us that they expected adult detainees to find their own way home, but they would facilitate telephone calls to assist their arrangements. At some suites we were told that detainees were given a letter or charge sheet to show that they had been held in police custody to claim free travel on public transport. While we recognised the positive intention behind this initiative, this breached detainee confidentiality, which the force needed to address through some alternative arrangements. Custody staff said, and our case audits and observations found, that police officers often provided transport to take children or vulnerable adults home safely, although we were told there were often lengthy waits to arrange this (see also paragraph 4.27).
- 5.4** Most person escort records (PERs) that we checked were completed to a good standard. However, there was an over-reliance on the use of loose-leaf forms to include details of medical conditions and any medications administered, rather than record this information in the PER. Many PERs also had additional documents attached, such as custody record front sheets and charge sheets, which were unnecessary.

Area for improvement

- 5.5 Pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release.**

Courts

- 5.6** Most court transfers took place in the morning, although Serco, the prisoner escort contract service, did sometimes return to suites to collect detainees later in the day. Where Serco could not return, custody staff made every effort to arrange police transport for detainees due in court to minimise their time in detention. There was, however, evidence that early cut-off times imposed by some courts led to the prolonged unnecessary detention of some detainees.
- 5.7** Two suites had facilities to allow a defendant to have their first hearing in a magistrate's court taking place from police custody via secure video link ('virtual court'). There were dedicated DDOs to manage these arrangements. Courts did not prioritise cases, often hearing them at the end of the court day. However, when individuals were remanded into prison custody they were generally transported that day.

Area for improvement

- 5.8** **The Metropolitan Police Service should engage with HM Courts & Tribunals Service to ensure that early court cut-off times do not result in detainees staying in police custody for unnecessarily long periods.**

Section 6. Summary of causes of concern, recommendations and areas for improvement

Causes of concern and recommendations

- 6.1** Cause of concern: The governance and oversight of the use of force in custody were not adequate to ensure that all use of force was proportionate and justified for the risk or threat posed. Not all use of force in custody suites was recorded, or the force used was not always accurately reflected in the custody record. Not all staff involved in use of force incidents completed individual use of force forms.

Recommendation: All use of force in the custody suites should be recorded, accurately reflect the force used, and be fully justified on the custody record. Governance and oversight of the use of force should ensure that all use of force is proportionate to the risk posed, and include comprehensive review of CCTV records. (S30)

- 6.2** Cause of concern: Strategic oversight of the provision of health care was poor, outcomes for detainees were inconsistent, and not all detainees received prompt access to medical care.

Recommendation: The force should have robust oversight of the delivery of health care services and assess the outcomes achieved for detainees. All detainees should receive a consistent service and have prompt access to medical care. (S31)

Areas for improvement

Leadership, accountability and partnerships

- 6.3** The force should ensure it has sufficient and sustainable staffing arrangements to deliver safe detention across its custody suites. (1.11)
- 6.4** The force should monitor data on diversity to ensure outcomes for detainees are fair, and be able to demonstrate that its custody practices meet the public sector equality duty. (1.19)

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

- 6.5** Custody staff should protect detainees' privacy wherever possible, particularly at booking-in desks, and detainees should be told they are being recorded while in custody. (3.4)
- 6.6** The force should ensure that detainees' individual and diverse needs are appropriately and consistently met. In particular by:
- providing relevant training for all custody staff to identify the individual needs of detainees across all protected characteristics;

- having facilities suitable for mobility-affected detainees in all suites or, where possible, directing these detainees to an appropriate alternative environment at the first point of contact;
 - providing improved support for female detainees, including offering them the opportunity to speak privately with a female member of staff and by routinely offering them access to a suitable range of sanitary items. (3.12)
- 6.7** The force should strengthen its approach to managing detainee risks, including by:
- ensuring all detainees who are intoxicated are placed on rousal checks;
 - answering cell bells promptly, only muting them with good rationale and proper authority, for the shortest time necessary, and subject to regular review;
 - having a consistent approach to shift handovers, ensuring that they involve all custody staff, share comprehensive information about detainees and include custody sergeants visiting detainees to check on their welfare. (3.22)
- 6.8** The force should consistently comply with all aspects of the PACE codes of practice. In particular by:
- ensuring that detainees unfit to receive their rights and entitlements when they are booked into custody receive these as soon as they are fit to;
 - ensuring sufficient copies of the latest version of PACE code C are readily available for detainees in all custody suites;
 - making custody staff aware of the availability and importance of translated documents for detainees and provide them in line with PACE code C, annex M. (3.38)
- 6.9** The force should minimise delays in progressing investigations so that detainees spend no longer than necessary in custody. (3.39)
- 6.10** The approach to PACE reviews of detention should be improved. In particular:
- the force must consistently comply with section 15.7, code C of PACE by reminding detainees that a review of detention has taken place while they were asleep;
 - reviews of detention should only be carried out by substantive inspectors or sergeants who are properly authorised by the force to act in the rank of inspector and perform the role as reviewing officer. (3.44)
- 6.11** When custody sergeants hand notices to suspects being released under investigation they should explain what it means and the consequences should they interfere with the course of justice. (3.48)
- 6.12** Complaints procedures should be adequately promoted in all custody suites. When complaints are made they should be dealt with in a consistent way and, where possible, while the detainee is in custody. (3.51)

In the custody cell, safeguarding and health care

- 6.13** The force should ensure that all custody staff take part in an annual fire drill. (4.7)
- 6.14** Strip searches should only take place when there are reasonable grounds to suspect a detainee may have concealed an article that they would not be allowed to keep. The grounds and justification for such a search should be fully recorded on the detainee's custody record. (4.15)
- 6.15** Detainee care should be improved. In particular, detainees should be routinely offered toilet paper, access to handwashing facilities and, those held overnight, a shower. There should be

a suitable range of reading materials that are actively offered, and all custody suites should have exercise facilities of an appropriate size and in a suitable location to provide detainees with access to fresh air and exercise. (4.22)

- 6.16** The force should ensure that children and vulnerable adults consistently receive early support from appropriate adults. (4.44)
- 6.17** The force should continue to work with its partners to ensure that children charged and refused bail are moved from custody to alternative accommodation provided by the local authority. (4.45)
- 6.18** Clinical governance arrangements should encompass detainee outcomes and include provision of confidential health complaints, integrated clinical incidents systems, quality assurance of practice and regular audit of medicine storage and systems to ensure the safe reconciliation of medicine stocks. Detainees requiring an assessment by a forensic medical examiner should be seen within agreed response times, which should be monitored as part of clinical governance. (4.52)
- 6.19** Health care staff should see detainees in private, subject to an individual risk assessment. (4.58)
- 6.20** Medication due for administration while detainees are at court should be sent with them, and detainees who smoke should have prompt access to nicotine replacement therapy if clinically appropriate. (4.59)
- 6.21** An electronic clinical record system shared by custody nurse practitioners and forensic medical examiners should be established as a priority to ensure health care practice is in line with professional standards, the Data Protection Act and Caldicott guidelines on the confidentiality of personal health information. (4.60)
- 6.22** Detainees should receive prompt and consistent access to in-suite substance misuse services. (4.63)
- 6.23** Detainees with acute mental health issues should receive prompt Mental Health Act assessments, and agreed transfers to hospital facilities should be carried out promptly. (4.70)

Release and transfer from custody

- 6.24** Pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release. (5.5)
- 6.25** The Metropolitan Police Service should engage with HM Courts & Tribunals Service to ensure that early court cut-off times do not result in detainees staying in police custody for unnecessarily long periods. (5.8)

Example of good practice

- 6.26** The in-house training programme for custody officers on mental health included service users and their direct experience of custody. (4.71)

Section 7. Appendices

Appendix I: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.⁹

Document review

Forces are asked to provide a number of key documents for us to review. These include: the custody policy and/or any supporting policies, such as the use of force; health provision policies; joint protocols with local authorities; staff training information, including officer safety training; minutes of any strategic and operational meetings for custody; partnership meeting minutes; equality action plans; complaints relating to custody in the six months before the inspection; and performance management information.

Key documents, including performance data, are also requested from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including: custody population and throughput; demographic information; the number of voluntary attendees; the average time in detention; children; and detainees with mental ill health. This information is analysed and used to provide contextual information and help assess how well the force performs against some key areas of activity.

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random, and a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week.¹⁰ The analysis focuses 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.¹¹

⁹ <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

¹⁰ 95% confidence interval with a sampling error of 7%.

¹¹ 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.

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected) to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include looking at records for children, vulnerable people, individuals with mental ill health, and where force has been used on a detainee. The audits examine a range of issues to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults, and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing their physical conditions, and observing operational practices and how detainees are dealt with and treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first hand. We also speak with other non-custody police officers, solicitors, health professionals and other visitors to custody to obtain their views on how custody services operate. We look at custody records and other relevant documents held in the custody suite to assess the way in which detainees are dealt with, and whether policies and procedures are followed.

Interviews with key staff

During the inspection we carry out interviews with key officers from the force. These include: chief officers responsible for custody; custody inspectors; and officers with lead responsibility for areas such as mental health or equality and diversity. We speak to key people involved in the commissioning and delivery of health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak with the coordinator for the Independent Custody Visitor scheme for the force.

Focus groups

During the inspection we hold focus groups with frontline response officers, and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

Feedback to force

The inspection team provides an initial outline assessment to the force at the end of the inspection, in order to give it the opportunity to understand and address any issues at the earliest opportunity. Following this, a report is published within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit approximately one year after our inspection to assess progress against our recommendations.

Appendix II: Inspection team

Kellie Reeve	HMI Prisons team leader
Fran Russell	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Mark Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Anthony Davies	HMI Constabulary and Fire & Rescue Services inspection officer
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Andrew Reed	HMI Constabulary and Fire & Rescue Services inspection officer
Stephen Eley	HMI Prisons health services inspector
Majella Pearce	HMI Prisons health services inspector
Matthew Tedstone	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Patricia Taflan	HMI Prisons researcher