



Report on an inspection visit to police custody suites in Enfield Basic Command Unit

18-19 May 2009

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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1. Introduction

This inspection of police custody suites in the London Borough of Enfield is part of a programme of joint work by HM Inspectorate of Constabulary and HM Inspectorate of Prisons. They contribute to the United Kingdom's compliance with its international obligations to ensure regular independent inspection of all places of custody¹. In each inspection, we examine force-wide strategies, treatment and conditions, individual rights and healthcare.

Enfield has two custody suites designated under the Police and Criminal Evidence Act (PACE) 1984 for the reception of detainees. Edmonton custody suite is open 24 hours a day, while that in Enfield is only opened when required, for example in response to a major football match. Both suites may hold adults, juveniles and immigration detainees, with around 4,210 detainees having been held in the previous six months. Inspectors visited both suites, as well as interviewing a sample of prisoners at HMP Pentonville who had previously been detained in Edmonton.

Strategic management was provided by the custody directorate of the Metropolitan Police Service (MPS), but with day-to-day management devolved to the borough commander. The custody directorate operated an internal inspection function. Responsibility for the custody estate lay with the Metropolitan Police Authority (MPA). The MPA also managed the work of the Independent Custody Visitors, who reported good relationships with custody managers and staff.

Custody teams in Edmonton were appropriately trained, permanent and suffered minimal staff turnover. This evidently assisted consistency of service delivery, which was generally well organised, respectful and professional. Provision was inevitably less consistent at the more infrequently opened Enfield suite. Relations with key stakeholders were good: work with the Crown Prosecution Service was well integrated, defence solicitors did not express any concerns to inspectors and there were strong local partnerships with the National Health Service, particularly regarding mental health.

Edmonton was a busy, efficient custody suite, with appropriate attention paid to the treatment of detainees. The needs of particular groups, including women, carers and juveniles, were assessed, but there was a need for better policy guidance and staff training on the treatment of juveniles. Accommodation was adequate, although graffiti was a problem, there were no hand washing facilities in-cell, access to showers and towels was poor, and there was no outdoor exercise area. Better communication with detainees was required on some basic issues, such as use of the cell bell, and there was no routine provision of toilet paper or female hygiene products. Better monitoring was also required of the use of strip searching, although its use did not appear excessive.

Staff took an appropriately diligent approach to ensuring adherence to individual rights, as specified in PACE guidelines. However, there was a lack of privacy for detainees needing to use the telephone, and no video link for court appearances. It was not easy for detainees to make a complaint while in custody, and there was little analysis or learning from patterns of complaints. Pre-release risk management was uncoordinated, but staff did make efforts to support juveniles and vulnerable adults on release.

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

Health services were generally good, although forensic medical examiners lacked some basic equipment, response times varied and their rooms were cluttered. Record keeping was reasonable, but medicines management required improvement. A good drug support service was provided, although there was no specific provision for juveniles or those with alcohol problems. Despite a lack of a dedicated mental health nurse, there was an effective crisis intervention team and good joint working with the local mental health trust.

This inspection of police custody suites in the London Borough of Enfield revealed an essentially positive picture, with appropriately trained and permanent staff delivering a generally well organised, respectful and professional service. There are a number of areas identified in the report where further improvements are needed but, overall, managers and staff responsible for police custody in the borough deserve credit for the good level of service that they have demonstrated.

Denis O'Connor
HM Chief Inspector of Constabulary

Anne Owers
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August 2009

2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have begun a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of all places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes, but at our *Expectations* for the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice².
- 2.2 The Metropolitan Police Service (MPS) has 77 custody suites designated under the Police and Criminal Evidence Act 1984 for the reception of detainees. Twenty-five are 'overflow custody suites', used for various operational matters such as charging centres for football matches or immigration detention. One suite had previously been used for Operation Safeguard (overflow from prisons). The remaining 51 custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.
- 2.3 This inspection was conducted in the two custody suites in the London Borough of Enfield. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and healthcare in both suites. A survey of prisoners at HMP Pentonville who had formerly been detained in the Edmonton custody suite was conducted by HM Inspectorate of Prisons researchers and an HM Inspector of Constabulary staff officer to obtain additional evidence (see appendix III).
- 2.4 The Edmonton custody suite was open 24 hours a day. Enfield was opened only when demand required, such as during a football match or under Operation Safeguard, to hold prisoners who could not be located in prisons due to overcrowding. Both suites held a mix of adults, juveniles and immigration detainees and had received nearly 4,210 detainees in the previous six months, an average of 23 each day. This included 693 juveniles, 562 women and approximately 79 immigration detainees.

Strategic overview

- 2.5 The MPS has a custody directorate within the Operation Emerald territorial policing team led by a commander, with day-to-day management delivered by a detective superintendent. The custody directorate has an internal inspection function. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs. Responsibility and accountability therefore rested with the borough commander, who was a chief superintendent.
- 2.6 The Metropolitan Police Authority (MPA) had responsibility for the custody estate, but did not specifically allocate portfolios of responsibility to members of the MPA and as such there was no defined MPA lead for custody. The MPA did, however, have an official who managed the independent custody visitors (ICVs) scheme and had the lead responsibility for reporting on custody issues. The borough was responsive to issues raised by ICVs. There was also an MPA member-led panel that reviewed and led on the custody suite building programme.
- 2.7 The MPS's asset management plan was stalled due to the wider economic situation, which had led to a 'rephasing' of building plans, with priority focused according to the most pressing

² Expectations for police custody are currently being redrafted and will be published in December 2009.

need. It was anticipated that it would be complete by the middle of 2011, with five new custody suites built over the next four years and the first new custody build starting in June 2009.

Treatment and conditions

- 2.8 Edmonton was a busy custody suite, but staff treated detainees with respect and explained their rights and entitlements. Detainees' diverse needs were identified through risk assessment, including the specific needs of women, carers and young people. All juveniles were automatically assessed as vulnerable and were subject to increased observations, but there was no MPS-wide or local guidance on how they should be cared for in custody and this was therefore inconsistent. No recent training had been offered in mental health awareness or suicide and self-harm. The use of strip searches was not monitored, but did not appear excessive. The irregular staffing of Enfield custody suite had resulted in what appeared to be a lack of clarity regarding first on scene procedures.
- 2.9 Detainees were not told how to use cell call bells. Cells contained mattresses and pillows, and blankets were available. Women could ask for hygiene products, but this information was displayed in English only. Underwear was not provided. Toilet paper had to be asked for and detainees could not wash their hands in the cells. Showers appeared to be rarely used. Only paper towels were available for anyone who did shower and the cubicles offered little privacy. Both custody suites contained graffiti, some of it offensive, although Enfield had less as it had recently been decorated.
- 2.10 Visits were not allowed. There was no exercise area and detainees had no time in the fresh air. There was little available to help detainees to pass the time. Smoking was not allowed and smokers were not automatically given nicotine replacement aids. Detainees were offered drinks, but not always regular meals. The food offered was good quality.

Individual rights

- 2.11 Detainees could access solicitors and appropriate adults, but telephone calls could not be made in private. Potential appropriate adults were properly risk assessed. Detainees could notify someone of their detention, but again calls were not private. A telephone interpreting service was used when necessary to inform a new detainee of their rights, and interpreters were used for other procedures. Detainees were not handcuffed in the custody area, but not all use of force was recorded or scrutinised. Interviews were carried out within PACE guidelines.
- 2.12 There was no video link for court appearances, but detainees were delivered to court reasonably promptly and cut-off times were less restrictive than is often the case elsewhere. No information was displayed about how to make a general or racist incident complaint and anyone wanting to complain was simply referred to the front desk.
- 2.13 Pre-release risk management was uncoordinated, with no specific policy in place. However, staff tried to offer support to juvenile and vulnerable detainees on release from custody and to ensure that follow-up advice from drugs workers and the mental health team was available.

Healthcare

- 2.14 Health services were good, but the forensic medical examiners' (FMEs') rooms were cluttered and there were issues around the storage of clinical waste. Doctors lacked basic equipment on site so carried everything they needed around with them. Medicine storage was haphazard

and stock lists were inaccurate, in some cases excessively so. Many medicines were out of date, as were some forensic testing kits. Efforts were made to ensure that the most required medication was available, but methadone was not issued even though some detainees received it regularly in the community.

- 2.15 Doctors were community based GPs and response times depended on location and urgency. Urgent cases, including those for evidential necessity, were appropriately prioritised. There were some concerns over the storage of confidential information. The drug support workers offered a good service, with hourly sweeps to pick up anyone who had not indicated they needed support. They offered advice and followed detainees through to the community, but there was no commissioned service for juveniles and no alcohol services.
- 2.16 There was no dedicated mental health nurse. A crisis intervention team responded to FME referrals. Arrangements for the use of a dedicated Section 136 suite worked well, with a joint policy between the mental health trust and the police, and regular liaison meetings.

3. Strategy

- 3.1 The MPS had a custody directorate led by a commander. Day-to-day management was delivered by a detective superintendent. There was an internal inspection function. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and accountability therefore rested with the borough commander, who was a chief superintendent. There was no defined MPA lead for custody, but an MPA official managed the Independent Custody Visitors Scheme and had lead responsibility for reporting on custody issues.

Expectation

- 3.2 There is a policy focus on custody issues at a chief officer level.

Findings

- 3.3 The territorial policing commander was the chief officer lead on custody for the MPS. The custody directorate had an inspection function: one police inspector and one health and safety officer had individual responsibilities for audit and inspection, health and safety and the implementation of 'guidance on the safer detention and handling of persons in police custody' (SDHP). The commander sat on the programme board for SDHP and was clearly focused on professionalising custody. He was also looking towards and planning for integrated prosecution teams and the use of virtual courts in the new custody suites.
- 3.4 Strategic policies were signed off at a strategic command level within the MPS and the custody directorate provided standard operating procedures (SOPs) that supported delivery of force policies by custody suites in each London borough. The SOPs covered a broad spectrum of matters, including use of police custody, use of closed-circuit television and guidance to custody staff on the supervision of detainees. They were designed to assist boroughs to deliver consistent levels of service, although responsibility and accountability for their delivery had been delegated to borough commanders.
- 3.5 The MPS had recruited its first team of nurses to complement the level of healthcare provided by its doctors, but these were not yet available at Enfield. The aim was to recruit 200 nurses by 2012 to ensure that each borough had a nurse on duty 24 hours a day. The issue of clinical governance was being revisited with a view to employing a full time member of staff.

Expectation

- 3.6 There is an effective management structure for custody that ensures that policies and protocols are in place and implemented and that there are mechanisms for learning from adverse incidents, rubbing points or complaints.

Findings

- 3.7 Enfield borough had two custody suites. Edmonton was the main custody suite. Enfield, the subsidiary unit, was used as an overflow facility or for dedicated operations. All custody

sergeants had received nationally approved custody training. Designated detention officers (DDOs) and police constable (PC) gaolers had received custody training before their deployment into custody suites. Custody training for sergeants and DDOs was delivered corporately. Custody training for gaolers was delivered at borough level as part of a training cycle and they had received custody-specific training that included first aid training. Refresher training was delivered at borough level. The custody teams in the custody suites were permanent teams, with police officers 'posted' into the roles, and staff turnover was minimal. They were well organised, respectful and professional. The borough commander was looking to release all PC gaolers back to frontline duties by fully developing the DDO role.

- 3.8 There were strong local partnerships with the National Health Service and accident and emergency departments. A tri-borough approach to mental health matters involving the boroughs of Haringey, Barnet and Enfield had begun in February 2009. All three boroughs had given up some staff to ensure this collaborative approach was a success and this innovative partnership arrangement worked commendably well.
- 3.9 There was an integrated prosecution team and the Crown Prosecution Service (CPS) branch crown prosecutor was based in an office at Edmonton police station. Quarterly meetings between the police and the CPS were facilitated. One-to-one consultation took place between police officers and the CPS and, while the police were aware of the escalation process in cases of dispute, it was rarely invoked because relations were good and disputes were resolved locally.
- 3.10 Defence solicitors did not express any concerns to the inspection team. They described relationships with the police as very good and said custody staff were professional in their approach. The borough commander chaired the borough criminal justice group, which had defence solicitors as partners. The locally based CPS crown prosecutor also attended group meetings, as did the local independent advisory group. This arrangement allowed partners to feed any issues of concern into the group.
- 3.11 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating adverse incidents. Adverse incidents were referred to as 'successful interventions' to encourage reporting and create a positive learning environment. Custody sergeants were unaware of the 'lessons learned' literature from the Independent Police Complaints Commission and did not know how to access it.
- 3.12 There was an MPA lead for the independent custody visitors (ICV) scheme, which was viewed as an important independent oversight mechanism. ICVs reported good relationships with the borough custody manager and with custody staff in general. The borough commander sometimes attended ICV meetings, which reinforced the good working relationships. ICVs visited Edmonton custody suite regularly and considerably exceeded their targets for weekly visits. Their reports were regular and clearly focused on prisoner welfare. ICVs were prepared to seek assurance on issues of concern. There was a sound system for recording these and a formal mechanism for feedback whereby the custody manager regularly attended bi-monthly meetings with the ICVs to provide comprehensive and timely information.
- 3.13 Complaints from detainees were not taken while they were in custody unless they were of a serious nature or concerned their treatment while within the custodial environment. There was no feedback loop from the Department for Professional Standards to boroughs or custody managers on the number or type of complaint made by detainees. This strategic weakness failed to identify opportunities for learning or solving the underlying causes of complaints.

However, complaints were reviewed locally before a decision was made on whether they should be forwarded to the Department for Professional Standards for further investigation.

- 3.14 The refrigerators and freezers at Edmonton were managed reasonably well, but were of poor quality. The door seals on two freezers were not working. This meant some sexual offence exhibits or samples at the top of the freezer could not be removed as they were encased in ice, while exhibit bags lower down had pools of water on them, indicating that forensic samples or DNA were not being stored at the correct temperature. A small number of PACE DNA samples had not been submitted to the National DNA Database and the reason for this was unclear.
- 3.15 Breath-testing machines were in open areas in reception, which meant there was no privacy for detainees who were subject of an ongoing enquiry and required to submit to breath test procedures.

Recommendations

To the Metropolitan Police Service

- 3.16 To ensure the implementation of corporate policies and the maintenance of corporate standards, the Metropolitan Police Service should consider putting the management of all custody suites under one operational command unit.
- 3.17 Police officers and staff should access the 'lessons learned' circular from the Independent Police Complaints Commission.
- 3.18 Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated.
- 3.19 The number and nature of complaints should be collated and analysed centrally with a view to feeding management information back to borough commanders and custody managers so the underlying cause of complaints can be identified with a view to problem solving these issues.
- 3.20 Consideration should be given by the Metropolitan Police Service to providing boroughs centrally with fridges and freezers that are of an industrial standard.
- 3.21 The ongoing issues within the Metropolitan Police Service surrounding the taking, storing and submission of DNA and forensic samples should be addressed as an urgent priority, including a referral to the forensic science regulator.
- 3.22 The breath test machines should be positioned so that investigation procedures can be carried out in private.

To the Metropolitan Police Authority

- 3.23 The Metropolitan Police Authority should allocate one authority member as lead for custody.

Good practice

- 3.24 *A tri-borough approach to mental health matters involving the boroughs of Haringey, Barnet and Enfield had begun in February 2009. All three boroughs had given up some staff to ensure this collaborative approach was a success and this innovative partnership arrangement worked commendably well.*

4. Treatment and conditions

- 4.1 The diverse needs of detainees were appropriately assessed by custody staff and we saw staff at Edmonton pay particular attention to the needs of juveniles. Only limited information was displayed and this was in English. Detainees were not told how to use cell bells or that they needed to ask for toilet paper and hygiene packs. No cells complied with the Disability Discrimination Act. Both custody suites contained graffiti and cells at Edmonton were in need of redecoration. Showers were not routinely offered at Edmonton and detainees were expected to use paper towels. Most custody records indicated that detainees were regularly offered refreshments and meals.

Expectation

- 4.2 The custody suites are properly maintained and ongoing maintenance work does not have a negative impact on the treatment and conditions of detainees.

Findings

- 4.3 Maintenance appeared to be done when facilities were closed. Edmonton had recently been closed by the borough commander for improvement and refurbishment work to be carried out. The custody suites were well maintained, the environment reasonable and all ligature points had been carefully removed. There was graffiti in cells, especially where the wooden plinths remained. Some of it was offensive and in need of removal. A lot of cells had gang-related postcode graffiti that marked out and reinforced gang activity in the community.

Expectation

- 4.4 Custody suite staff can safely evacuate the custody suite in the event of a fire.

Findings

- 4.5 Fire evacuation procedures were in place, plans were updated and there had been a recent live evacuation, although no routine fire training had taken place.

Expectation

- 4.6 The diverse needs of detainees are met. This includes the specific needs of:
- women
 - black and minority ethnic detainees
 - foreign nationals
 - those with a disability
 - immigration detainees
 - those with different religious needs.

Findings

- 4.7 Detainees' needs were primarily identified and assessed through the risk assessment tool generated by NSPIS. This incorporated both a self assessment and a custody officer assessment and gave detainees the opportunity to indicate if they were new to custody or had communication issues, such as literacy or language difficulties. All juvenile detainees were assessed as vulnerable, which triggered more frequent observations. Staff were aware of the needs of younger detainees, took time to explain what would happen next and knew to contact an appropriate adult.
- 4.8 Women were asked as part of the assessment whether they wanted to talk to a female member of staff in private. Staff said there were no problems accessing a female detention officer and the gender balance of staff we saw at Edmonton was appropriate to meet the needs of the detainees in custody at that time. All detainees were asked if anyone was dependent on them and we saw custody staff allowing a telephone call so that a detainee could arrange for his brother to be collected from school.
- 4.9 Detainees were asked about their nationality and ethnicity. Custody records indicated that interpreters were used when required and that all foreign national detainees were made aware of their rights. Other procedures included notifying the relevant consulate. The notice of entitlement was available in a range of languages other than English.
- 4.10 All detainees were asked if they had any special dietary needs.
- 4.11 Both custody suites held a range of religious text books and prayer mats, and cells identified where East was for Muslim detainees who wanted to pray. Staff said an officer was responsible for ensuring detainees' religious needs were met. Detainees were asked during assessment about any 'other detention-related issues', which was when they could raise any religious or cultural needs. However, the purpose of this question was not clearly explained to detainees.
- 4.12 Access to Enfield custody suite was reasonable as there were no steps to negotiate, but Edmonton had a small step from the yard to the custody suite. Staff said detainees with mobility difficulties were escorted through a step-free side entrance when necessary.
- 4.13 The custody desk at Enfield was above average height, but provided a level of confidentiality if detainees were being booked in individually. The Edmonton custody desk was of a more appropriate height and provided sufficient privacy if one or two detainees were being booked in. We saw a detainee being booked in while another detainee was making a private telephone call, which was not appropriate and did not offer either detainee the level of privacy they required.
- 4.14 Staff at Edmonton treated detainees politely and with respect. Efforts were made to ensure that detainees understood what was happening to them and we observed good interactions between staff and detainees, particularly when some detainees were being challenging. No detainees were held in Enfield during the inspection.

Expectation

- 4.15 Custody staff have the skills and competencies to manage detainees at risk of harm to themselves.

Findings

- 4.16 Custody staff used the risk assessment, their own observations and any other information that might be contained on the computer database to assess a detainee's risk to themselves. The risk assessments required detainees to provide information about any medical conditions or if they were under the influence of drugs or alcohol. Custody records indicated that FMEs attended when requested and had seen the detainees in all but two cases, where the detainees had been released before the FMEs arrived.
- 4.17 Detainees were asked about any history of self-harm or attempted suicide. Any previous self-harm attempt in custody was marked on the computer and flagged for custody officers. All detainees we interviewed said they had been asked about any history of harming or any current thoughts of harming themselves.
- 4.18 Staff at both custody suites said every effort was made to complete the risk assessment and that any detainee unwilling or unable to go through the process was placed on increased observations until they were able to do so. The custody sergeant at Enfield said constant supervision might be appropriate, but would be determined on a case by case basis.
- 4.19 Life signs monitoring was not used and there did not appear to be an over-reliance on closed-circuit television (CCTV) to observe detainees. Custody sergeants at both suites said constant supervision required staff to engage with the detainee rather than just observe them.
- 4.20 The staff handover we observed at Edmonton included a detailed exchange of information and any outstanding issues and risks identified were thoroughly discussed. All cells were checked by detention officers before use and the mattress placed against the wall to indicate that the check had been completed.
- 4.21 Staff we spoke to had not received any recent suicide and self-harm training. Staff had received training as part of their initial custodial training, but for some this was as long ago as five years. Staff carried anti-ligature knives, but staff at Enfield appeared to be unaware of the safer detention handling procedures in the event of a detainee attempting to commit suicide or how detention officers should respond.
- 4.22 There was a lack of consistency in how juveniles at risk of harm or increased vulnerability would be supported. Staff at both custody suites said they would not allow appropriate adults to remain in the detention room with a young detainee, although there was some flexibility, albeit not encouraged or clearly defined, to allow them to sit with detainees in a more appropriate room.

Expectation

- 4.23 **Custody staff have the skills and competencies to deal with detainees at risk of harm to others.**

Findings

- 4.24 Cells were not shared under any circumstances. Information from the risk assessments and from the arresting officers was used by custody officers to determine a detainee's risk of harm to others. They also took into account the detainee's demeanour during the risk assessment, the nature of the offence and any information on NPSIS.

- 4.25 Detainees were not routinely strip searched unless they had been arrested for specific offences such as violence, drugs or possessing weapons. The strip search included squatting. There was no separate local record of when strip searches were carried out. This information was collated centrally, but use of strip searching across custody suites in the borough was not monitored.

Expectation

- 4.26 All cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to promptly.

Findings

- 4.27 All cells were equipped with cell call bells, but their purpose and use was not explained to detainees either verbally or in writing. Staff said individual cell bells could be isolated and we saw this done when a particularly challenging detainee was abusing the cell call bell system. The detainee concerned was appropriately monitored through CCTV and visits to his cell.
- 4.28 None of the detainees we interviewed said they had been told about use of the call bell, although most were aware of its function. They would have benefited from an explanation as cell bells had to be used to request toilet paper and to use the sink. It might also have prevented some detainees from over using their cell bells.
- 4.29 Staff responded promptly to cell call bells and recorded the contact they had with detainees. Cell bells were in good working order and staff said they were checked regularly.

Expectation

- 4.30 All areas of the custody suite that are used by detainees are clean, safe and in a good state of repair.

Findings

- 4.31 Edmonton had 11 cells and three detention rooms. Eight cells were monitored by CCTV. Cells were reasonably clean, but had ingrained graffiti on the wooden bed plinths, walls, floors, door frames and doors. The graffiti included names and postcodes and cells were in need of redecoration. Cracks or gaps in cells that could have been used as ligature points had been removed and one cell was out of use due to the observation hatch being removed.
- 4.32 The two detention rooms and five cells at Enfield had recently been redecorated and the cells were mainly free of graffiti. Three cells and one detention room were monitored by CCTV and a notice on cell ceilings informed detainees of this. Both detention rooms had graffiti etched into the wooden plinths and some of it was offensive. The walls and floors were clean. Staff said contract cleaners maintained the cells and communal areas and dealt with any spillages.
- 4.33 Neither custody suite had a procedure for certifying that a cell had been clear before use or for dealing with detainees who might be suspected of writing graffiti. Both small holding areas were also clean, but contained little information about services available to detainees such as legal, drug and alcohol services.

- 4.34 The cells had minimal natural light, but in-cell electricity controlled at the front desk could be dimmed or switched off at the detainee's request. Edmonton had little ventilation and the custody suite was very warm on the day we inspected, particularly when busy.
- 4.35 No cells had been adapted to accommodate a detainee with physical disabilities. Cells had no grab bars and all beds were low to the ground.
- 4.36 Chairs were not bolted down in interview or consultation rooms.

Expectation

- 4.37 Detainees are provided with a mattress, pillow and clean blankets.

Findings

- 4.38 Mattresses, pillows and clean blankets were available at both custody suites and all cells we inspected were equipped with mattresses and pillows. Enfield cells already had blankets in them while at Edmonton they were supplied on request.
- 4.39 Clean and dirty blankets were kept separate and we saw used blankets being collected by contracted cleaning services. Where blankets were issued or requested by detainees, this was recorded in custody records.

Expectation

- 4.40 Hygiene packs for women are routinely provided.

Findings

- 4.41 Notices displayed in both custody suites informed female detainees that they could request hygiene products, but were only in English. Staff said women were also told this during the booking in process, but we did not observe this. One female detainee said she had not been told about the availability of hygiene packs, but she had seen and was able to read the notices.

Expectation

- 4.42 A no-smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

Findings

- 4.43 Smoking was not allowed in either custody suite and detainees we spoke to knew this. However, they were not aware that they could get nicotine replacement patches from the doctor.

Expectation

- 4.44 Detainees are offered sufficient refreshments at recognised mealtimes and at other times that take into account when the detainee last had a meal.

Findings

- 4.45 Meals for detainees held at Edmonton were provided from a staff canteen from Monday to Friday and during the day on Saturday. Microwave meals were offered at other times. The quality and range of the canteen meals were good. They were substantial and more nutritionally balanced than the microwave meals. At a lunch time during the inspection, a range of sandwiches was available alongside savoury buns and hot and cold drinks. Detainees with a specific dietary need were catered for. Significantly more detainees than at comparator police suites said the food was suitable for their dietary requirements. Custody records indicated that detainees were usually offered meals and drinks at regular intervals. However, the custody record of one detainee held for nearly two days suggested that he had been offered only one meal.
- 4.46 Microwave meals were available at Enfield and offered a range of meals to meet most dietary and cultural needs. The meals were not nutritionally balanced, but were sufficient given the short time we were told detainees were held. Staff said meals were offered throughout the day and this was largely supported by entries in custody records.

Expectation

- 4.47 Detainees are able to use a toilet in privacy, and toilet paper and hand washing facilities are provided.

Findings

- 4.48 All cells in both custody suites had integral toilets, but only those at Enfield were screened. Toilets in cells covered by CCTV were obscured on the monitors, allowing the detainees some privacy. Toilets could be flushed from inside the cells, but detainees had to ring their cell bells to ask for soap, toilet paper and to be let out to wash their hands in a communal sink. Notices advising detainees that they had to request toilet paper were displayed outside the cells and we did not see any detainees given this information verbally.

Expectation

- 4.49 Detainees whose clothing is seized are provided with suitable alternative clothing.

Findings

- 4.50 Both custody suites had a stock of paper suits. We were told these were not used and that detainees whose clothes were not appropriate or had been seized for evidential purposes were offered white jogging bottoms and tops in a range of sizes. Black plimsolls were also available. We saw two detainees wearing the jogging suits.

Expectation

- 4.51 Changes of clothing, especially underwear, are facilitated.

Findings

- 4.52 Edmonton custody suite allowed family and friends to bring clothes in, particularly for detainees who were going to remain in custody for a long time. This was not allowed at Enfield, although staff said this was mainly because detainees were not held for long periods. Access to underwear was particularly important as neither custody suite held stocks to distribute as required.

Expectation

- 4.53 Detainees are offered the opportunity to have a shower.

Findings

- 4.54 Custody records indicated that some detainees were offered a wash before attending court, but showers were not routinely offered. Neither of the two showers at Edmonton was screened, so detainees using them had no privacy. The two showers at Enfield were located along the same corridor as the cells and were appropriately screened and reasonably clean. Both custody suites provided only paper towels, which were inadequate for the purpose of showering.
- 4.55 During the inspection, two detainees who had been in custody for over 24 hours and were attending court in the morning were not offered showers or toothbrushes, even though both were available. They complained about this on their return from court and were told they would be able to shower. However, the detention officers on duty said they could not facilitate these showers and would hand them over to the evening staff. The reason for this was unclear as there were enough staff on duty to supervise. The detainees were offered a shower in the evening.

Expectation

- 4.56 Detainees have access to a period of outdoor exercise.

Findings

- 4.57 Neither custody suite had an exercise area. Staff said detainees could be placed in the caged area at the entrance to the custody suites if necessary, but this was a confined space that offered little opportunity to move around. It was particularly unsuitable for detainees who had been in custody over 24 hours. None of over 40 custody records we reviewed showed that exercise or time in the fresh air had been offered to detainees.

Expectation

- 4.58 Those held in custody are provided with suitable reading material.

Findings

- 4.59 None of the custody records we looked at indicated that the detainee had been offered something to read. Both custody suites had a limited selection of books in English alongside

some religious reading materials, but there were no magazines or newspapers and nothing for detainees who did not speak English.

Expectation

- 4.60 Visits are allowed, especially for those held for more than 24 hours.

Findings

- 4.61 Neither custody suite allowed visits. At Edmonton, visitors could bring in clothes, but could not visit a detainee. The practice of allowing food to be brought in had been stopped.

Recommendations

- 4.62 Fire training should be given to all custody staff and fire evacuation drills practised regularly. A notice setting out the actions to take in the event of a fire or evacuation should be posted in custody suites.
- 4.63 Custody officers should explain what 'other detention related issues' covers so that detainees are clearer about the question and its relevance to their circumstances and needs.
- 4.64 Detainees should be offered an appropriate level of privacy when being booked in and when making or receiving a telephone call at the front desk.
- 4.65 Custody sergeants should have a good understanding of the safer custody handling procedures, particularly in relation to incidents of suicide and self-harm.
- 4.66 A policy for the management of vulnerable juvenile detainees should be developed, implemented and consistently applied.
- 4.67 The appropriateness of strip searching of detainees should be monitored locally when dip sampling records.
- 4.68 The use of cell bells should routinely be explained to detainees, and detainees should particularly be informed that they need to use the call bell to ask for toilet tissue and to use the wash basin.
- 4.69 Adapted cells should be available for use by detainees with a disability.
- 4.70 Furniture in interview and consultation rooms that could be used as weapons should be bolted to the floor.
- 4.71 Female detainees should routinely be told that hygiene packs are available and how they can be accessed.
- 4.72 The holding areas in custody suites should display information about services available to them.
- 4.73 On an individually assessed basis, nicotine replacement should be available to smokers.

- 4.74 A range of age-appropriate reading material, including some in relevant languages other than English, should be provided and detainees told that this is available.
- 4.75 A force-wide custody policy to address graffiti should be developed and graffiti should be properly removed from all cells.
- 4.76 Detainees should be offered a shower, particularly if they are held for 24 hours.
- 4.77 Towels should be provided to detainees who want to take a shower.
- 4.78 Detainees should be offered regular meals and drinks and this should be recorded in custody records even when refreshment is refused.
- 4.79 The toilets at Edmonton should be screened.
- 4.80 Toilet paper should be provided in cells.
- 4.81 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air.
- 4.82 A range of age-appropriate reading material, including some in relevant languages other than English, should be provided and detainees told that this is available.
- 4.83 Visits should be allowed for those detained more than 24 hours and for young people.

5. Individual rights

- 5.1 Custody was authorised by custody sergeants for every detainee. Detainees could have someone informed of their whereabouts and were given access to legal representation, appropriate adults and interpreting services as necessary. Staff were not trained in child protection or the distinctive needs of children and young people, but tried to ensure they were cared for according to their needs. PACE codes were adhered to during interviews and appropriate rest periods given. Most detainees were released within 24 hours and there was evidence of some risk management on release, although there was no formal policy or procedures. Detainees were not given information about making complaints and there was no separate monitoring of racist complaints.

Expectation

- 5.2 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

Findings

- 5.3 Custody was authorised for every detainee by the custody sergeant who also completed the initial risk assessment and giving of rights. Records and our observations indicated that detention lasted no longer than necessary except that detainees arriving at night were given eight hours rest immediately, which could impact on the length of time in custody (see paragraph 5.28). Some immigration detainees were held for up to five days due to delays within the UK Border Agency (UKBA) and its processes. Few detainees held at Enfield custody suite were there for more than a few hours. Reviews were carried out by inspectors in good time and acceptable reasons were given in the few cases when reviews were late.

Expectation

- 5.4 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts.

Findings

- 5.5 As part of the initial assessment (see paragraph 4.7), detainees were asked if they wanted someone informed of their whereabouts. We saw all detainees asked who they wanted informed and those who wanted to do so could make the telephone call themselves. Several attempts were made if the person concerned was unavailable. Detainees were also informed in writing of this right and this information was available in a range of languages.

Expectation

- 5.6 Detainees who have difficulty communicating are provided for.

Findings

- 5.7 As part of the initial assessment, detainees were asked about their ability to read and write and understand English. Custody sergeants checked how well detainees understood English and whether they had any other communication difficulties. A telephone interpreting service was used to explain rights when booking in detainees who did not understand English. Interpreters were subsequently available to help detainees during interviews and other processes. Sign language interpreters were also available. Out of 50 custody records reviewed, eight indicated that the detainee did not understand English and an interpreter had been provided in each case. In one case, a sign language interpreter had attended.

Expectation

- 5.8 All custody staff recognise and understand the distinctive needs of children and young people.

Findings

- 5.9 Custody staff had no formal training in child welfare or child protection issues and no enhanced Criminal Records Bureau (CRB) checks had been carried out on staff working in the custody suite. There was no distinct policy relating to the treatment of young people in the custody suites. Staff demonstrated an understanding of how custody might impact differently on a younger person and there were some procedures in place to acknowledge this. However, most procedures were the same as for adults.
- 5.10 Custody records indicated that appropriate adults were called in when required. Young people were placed in one of three detention cells until an appropriate adult arrived, but it was then unlikely that they would be able to wait with the young detainee.

Expectation

- 5.11 All custody staff treat children and young people according to their distinct needs.

Findings

- 5.12 All children and young people were automatically placed on at least half-hourly observations when received into custody unless the initial risk assessment showed that more frequent observations were necessary. Young people were placed in one of three cells closest to the booking in desk, one of which was covered by CCTV. If more than one cell with CCTV was required, a young person could be held in a different cell for that reason.
- 5.13 Custody sergeants carried out an assessment of the nominated appropriate adult. This included a police national computer check for serious offending. Appropriate adults were required to be over 18 years and not involved in the current proceedings. In one case during the inspection, a young person's request that his mother be contacted as an appropriate adult was refused on the basis that she was involved in his case as a witness. The Rainer North London appropriate adult service provided a 24-hour service and there were four adults available for call out. Custody records indicated that where an adult was not immediately able to attend and the circumstances of the case allowed, the young person was bailed to a more

appropriate time. Due to the PACE Code C definition of 'juveniles', appropriate adults were not called to 17 year olds, unless they were otherwise defined as vulnerable.

- 5.14 Staff made every effort to ensure that young people were released into the custody of a willing and appropriate adult.

Expectation

- 5.15 **Police custody is not used as a place of safety for children and young people under section 46 of the Children Act 1989.**

Findings

- 5.16 Custody sergeants were actively involved with local courts and services to ensure that the custody suite was not used as a place of safety for children and young people. We could find no record of such use of the custody suite.

Expectation

- 5.17 **Persons detained who have dependency obligations are catered for.**

Findings

- 5.18 In response to the findings of inspections carried out in other London boroughs, the initial assessment of detainees had been amended to include a question about dependency obligations. We saw one detainee allowed to make a telephone call to arrange for his younger brother to be collected from school. Custody records contained further examples where dependency obligations were catered for, including one detainee who was released on bail to enable him to return home in sufficient time to care for his mother.
- 5.19 There were no formal arrangements with social services or other organisations such as Age Concern to cater for detainees who were sole carers or who could not make alternative arrangements for dependants. Staff said they would contact a child's school or social services if there was no other alternative, but could not remember when this had last been necessary.

Expectation

- 5.20 **All detainees are able to consult with legal representatives in private for free. Those under the age of 18, vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present.**

Findings

- 5.21 A duty solicitor scheme provided free legal and specialist immigration advice for detainees. Detainees could meet legal advisers in separate consultation rooms when required. We also saw several detainees consult with legal advisers by telephone, but the telephone used was on the main custody desk and did not afford sufficient privacy.
- 5.22 Legal advisers attended within a reasonable time and we saw a legal adviser who had just completed one case agreeing to provide advice for another detainee who had just arrived. She

said that, in her experience, Edmonton provided the best facilities and service to legal advisers, with few delays and helpful staff who kept her regularly updated by telephone so that she could attend when required and minimise waiting time. When detainees declined the right to legal advice and said why, the reasons given were recorded.

- 5.23 Appropriate adult services included an out-of-hours service (see paragraph 5.13). Custody records and our observations indicated that vulnerable adults, those with learning disabilities and young people were not interviewed without an adult in attendance. However, custody staff continued to adhere to the PACE definition of a child, which meant that detainees aged 17 were not provided with an appropriate adult.

Expectation

- 5.24 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit, unless in circumstances provided for under PACE.

Findings

- 5.25 Custody records and our observations indicated that this did not happen. One detainee in the custody suite during the inspection was under the influence of alcohol and was not interviewed until declared fit by the medical examiner. His custody record reflected this and the additional observations that had been put in place to ensure his safety.

Expectation

- 5.26 Detainees are not deliberately denied any services they need during the interview process and are granted a period of eight hours continuous break from interviewing in a 24-hour period.

Findings

- 5.27 The interviews held during the inspection were not over long and detainees being interviewed were given breaks. Custody records indicated that an eight-hour rest was given in 24-hour periods. Legal advisers confirmed that appropriate rest periods were given.
- 5.28 Detainees brought into custody at night were given eight hours rest immediately, which could impact on how long they spent in custody and lead to a delay in their case being dealt with. Custody sergeants said this was because many people brought in at night were tired and needed rest before being interviewed and because interviewing staff were not as readily available as they were during the day.

Expectation

- 5.29 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

- 5.30 We could find no recent examples of detainees being handcuffed in the custody area and staff could not recall when it had last happened. They said handcuffs or leg restraints would be

used only if a detainee was particularly violent and a risk to themselves or others and de-escalation techniques had not been effective. Any use of handcuffs would be recorded in the detainee's custody record. A use of force form was available on NSPIS, but staff said they did not use it.

Expectation

- 5.31 Detainees who have been charged appear at court promptly either in person or via video link.

Findings

- 5.32 Local arrangements meant detainees could appear in court the same day if the court was contacted by 3pm on weekdays and 2pm on Saturdays. Where circumstances allowed, some detainees were bailed rather than held in custody overnight. Video link services were not yet available.

Expectation

- 5.33 Detainees are told how they can make a complaint about their care and treatment and are enabled to do so if they wish.

Findings

- 5.34 No written information was displayed in the custody suite and detainees were not routinely given information on how to make a complaint. Staff said they would refer any detainee who wanted to make a complaint to staff in the police station front office, who would take the details and pass them to the appropriate person. They also said that if a detainee made a complaint of assault by staff, photographs would be taken and a medical examiner called to examine them.

Expectation

- 5.35 There is an effective system in place for reporting and dealing with racist incidents.

Findings

- 5.36 The system for reporting and dealing with racist incidents was the same as for all other complaints. No information was displayed or given to detainees about how to make such a complaint.

Expectation

- 5.37 All detainees can consult a copy of the PACE Code of Practice C.

Findings

- 5.38 There were two copies of the PACE code of practice 2005. We saw detainees being made aware of these and offered the chance to consult them. Other detainees confirmed that this had been the case.

Expectation

- 5.39 Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

- 5.40 Legal representatives were automatically given a copy of the custody record when they attended the custody suite to see a client and said they had no problem getting a copy after a detainee's release. Staff said a copy of the custody record would be sent to detainees after release on request, although anecdotally few had actually done so.

Expectation

- 5.41 Pre-release risk management planning for vulnerable detainees is conducted to ensure they are released safely.

Findings

- 5.42 There was no formal policy for risk management planning on release. Staff made every effort to release young people into the custody of a willing appropriate adult and contacted the families of other vulnerable detainees to collect them if possible. Custody records showed that one young person who could not speak English and was unsure of his address was taken home on his release late at night by an officer and interpreter. Detainees with mental health problems could be referred to the mental health team. A drugs worker was available for those with substance use problems and could offer up to five future appointments for detainees seeking their services. However, the drugs worker was not contracted to offer a service to young people.

Recommendations

- 5.43 Appropriate adults should be allowed to wait with juveniles in the custody suite.
- 5.44 Detainees aged 17 years should be provided with an appropriate adult.
- 5.45 All custody staff should receive specialist training in the care of children and young people and all policies should reflect their particular needs.
- 5.46 Staff should undergo enhanced Criminal Records Bureau checks for working in the custody suite.
- 5.47 Custody staff should consider the need to avoid delays for detainees taken into custody during the night and make arrangements for interviews to take place within a reasonable time.
- 5.48 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites.

- 5.49 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on.
- 5.50 The pre-release risk management policy should be implemented consistently, particularly for vulnerable and young people, with actions taken recorded on NSPIS. Custody staff should receive training in this process.

6. Healthcare

- 6.1 Health services were provided by forensic medical examiners (FMEs) working to a contract with the Police Authority. They provided a satisfactory service. Just over half of respondents to our survey rated the quality of healthcare as good or very good. Record-keeping was reasonable, although there was no conformity of record-keeping between clinical staff. Medicines management was poor despite the recent introduction of new guidelines, including standardised stock lists. There was no liaison or diversion team for detainees with mental health issues, although detainees could be referred to the local crisis intervention team and arrangements for those detained under Section 136 of the Mental Health Act (1983) were good. Services for adults with drug problems were reasonable, but services for juveniles and adults with alcohol issues were less robust.

Expectation

- 6.2 Detainees are treated by healthcare professionals and drug treatment workers in a professional and caring manner that respects their decency, privacy and dignity and is sensitive to their situation and diverse needs, including language needs.

Findings

- 6.3 We witnessed consultations where staff demonstrated a professional and caring manner towards patients and showed respect for their privacy and dignity. Doctors took time to put patients at ease and provided information and advice. They all made it clear that the police would also see anything they wrote about the patient as it was put on to the police computer system. Fifty-four per cent of those surveyed, better than the comparator of 27%, rated the quality of healthcare as good or very good.
- 6.4 Most FMEs were male. Although it was reported that female detainees could request to see a female doctor, in practice this could not be accommodated and staff seemed surprised that this might be an issue. None of the detainees we interviewed had been asked whether this might be of concern to them. There were robust arrangements to ensure that a female chaperone was always available on request. There was no signage on the outside of the door to the medical examination room at Edmonton and, although the door was guarded by a key press, there were no curtains around the examination couch sited against the wall opposite.
- 6.5 Both custody suites served a multicultural population, but written health information was mostly available in English only. Telephone interpreters were used as appropriate, although we saw one medical examination take place using crude sign language. This was not referenced into the respective medical record.
- 6.6 The team of drug treatment workers who had an office and consultation base at Edmonton station were employed by Westminster Drug Project (WDP), which was in turn commissioned by the local drug action team to provide a seven days a week advisory and assessment service. Most written drug information was available in English only and in a single format, although some key documents were provided in a range of languages. Interpreters were used by WDP staff to assist detainees whose first language was not English. Sixty-three per cent of those surveyed, again better than the comparator of 38%, said they had been offered the chance to see a drug or alcohol support worker.

- 6.7 There was no corresponding drug treatment worker service for juveniles (see paragraph 6.55).

Expectation

- 6.8 **Clinical governance arrangements include the management, training and supervision and accountability of staff.**

Findings

- 6.9 There was a lack of robust clinical governance arrangements. The custody suites lacked established healthcare policies and protocols to provide a consistent minimum standard of healthcare delivery. It was reported that a range of policies was available to the staff on the intranet, but custody staff we spoke to were unable to demonstrate any awareness of clinical governance arrangements or lines of responsibility. Healthcare policies and protocols were not readily available to the FMEs.
- 6.10 Clinical governance arrangements for the FMEs were not clear. A new contract between individual FMEs and the Police Authority (with the intention that the services were provided for the Commissioner within the Metropolitan Police Forensic Medical Service) had been introduced a few months previously, but did not explicitly state who would carry out appraisals or ensure that FMEs undertook relevant professional development. However, we were told that a medical director was soon to be appointed and would take on this role among other duties. There was no monitoring at a local level of the contracts, although we understood this was carried out across the Metropolitan Force.
- 6.11 There was no evidence that a training needs analysis had been undertaken to determine the training needs of healthcare professionals engaged in delivering health services to detainees.
- 6.12 WDP, which provided the drug arrest referral service, had its own governance arrangements. These included systematic monitoring and audit arrangements against its commissioned service, with established feedback mechanisms to the drug and alcohol team.

Expectation

- 6.13 **Patients are treated by healthcare staff who receive ongoing training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular healthcare needs of detainees in police custody.**

Findings

- 6.14 Most FMEs also worked as GPs in the community, so were able to keep up to date and undertake training, such as resuscitation courses, through their other employment. Training registers were not readily available and the contract with individual FMEs did not state what ongoing professional training and development was required (see paragraph 6.11). Clinical supervision did not occur.
- 6.15 WDP team members were provided with a comprehensive induction and mandatory training programme. They received annual appraisals with corresponding personal development plans through WDP line management. There was a monthly supervision framework with sufficient

staffing to ensure that this could be delivered as scheduled. Supervision notes were held by the supervisee. No training had been provided by the constabulary.

- 6.16 It was reported that Mental Health Act and Mental Capacity Act training had not been provided to custody staff or FMEs. Safeguarding children update training had not been provided to all.

Expectation

- 6.17 Clinical examinations are conducted out of the sight and preferably out of the hearing of police officers. Treatment rooms provide conditions that maintain decency, privacy and dignity. Infection control facilities are implemented. There is at least one room that is capable of being used for the taking of forensic samples and it is clean.

Findings

- 6.18 There was one clinical examination room at Edmonton and another at Enfield. The Enfield room was extremely hot, with inadequate ventilation. Both rooms were near to the main desk. A designated detention officer (DDO) usually waited outside when detainees were being seen, although we saw one actually in the room without the patient being asked whether this was acceptable.
- 6.19 The clinical room at Edmonton was accessed by using a key press, but there was no engaged sign on the door, which could compromise privacy as there was no screening around the examination couch. Each room had a couch with a paper roll. Both rooms were poorly laid out and poorly equipped. FMEs carried their own examination equipment with them from station to station as there was none available in the clinical rooms. There was no inventory available or monitoring of the standard of equipment being used.
- 6.20 Fridge temperatures were not taken or recorded and the fridges required urgent defrosting. The sharps boxes were not dated, timed or signed on opening and contained multiple non-sharp general and clinical waste items. There was also a mixing of general and clinical waste in dedicated yellow bags. Staff said sharps bins were not emptied regularly, but only when full. There was no antibacterial hand cleanser in the room.
- 6.21 The clinical rooms were adequately cleaned by the station cleaner, but there did not appear to be any cleaning schedule or standard and there was a layer of dust on high ledges. A previous internal inspection by the custody directorate had highlighted that the room was not forensically clean and that the chair used by the detainee was made of soivable material and could not be forensically cleaned, but no steps had since been taken to rectify the situation. There was no evidence that an environmental risk assessment had been undertaken and there were multiple small areas where remedial maintenance work was required.
- 6.22 While both clinical rooms contained a range of forensic sampling kits, there was no stock rotation of these and we found out-of-date kits mixed with in-date kits in both suites.

Expectation

- 6.23 All medications on site are stored safely and securely, and disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

Findings

- 6.24 Guidance for the security, administration and disposal of drugs and medicines in custody had recently been introduced to ensure that a safe regime for the administration of medication to those in custody was maintained. There was a stock list in each room and a new drugs cupboard in the room at Edmonton. However, the doctors we spoke to were not clear about the new guidance and our investigations revealed that the stock list was not adhered to in either suite, the medications were arranged in a haphazard way, there was no systemised approach to the ordering, storage, stock rotation or disposal of drugs with the overstocking of some items and under-ordering of others, and there were multiple drugs out of date. Permanent custody officers were unaware of disposal arrangements for out-of-date drugs. Drug reference books were out of date. There was no adrenaline stock, despite it being on the stock list, and no anaphylaxis kit.
- 6.25 Other parts of the policy, such as having a logbook for recording schedule 4 and 5 medications and the correct recording for the administration of medications, were also not followed. The recent internal inspection by the custody directorate had highlighted that there was no 'dip-sampling' regime to check the accuracy of custody record entries.
- 6.26 Doctors also carried medications with them, but not all of them had a lockable case. One doctor said he provided his own medications rather than using those supplied by Forensic Medical Services to be sure he had the relevant medications to hand, particularly for those with a drug or alcohol problem.
- 6.27 It was reported that following medical assessment, the FME could prescribe and dispense enough medication to cover the expected detention period of the detainee. The medication was placed in a sealed plastic bag with instructions for administration written into the electronic medical record. We did not witness this during the inspection.
- 6.28 Proprietary and prescription drugs, including controlled drugs, in the possession of detainees on arrest were stored in plastic bags and attached to the individual's named clipboard. There were no arrangements to ensure they were securely locked away. This was contrary to current legislation and national guidance. Controlled drugs seized as evidence of a suspected crime were bagged, labelled and stored appropriately in a locked cupboard.

Expectation

- 6.29 **All equipment (including resuscitation kit) is regularly checked and maintained and all staff (healthcare and custody staff) understand how to access and use it effectively.**

Findings

- 6.30 There was an automated external defibrillator (AED) at each custody suite. The AED at Edmonton was checked daily, but the defibrillator pads were out of date. The defibrillator at Enfield was also checked, although the checking form looked like it had only just been introduced. There was no evidence of annual servicing of either AED. There was a rescu-vac pump (for suction) at each suite, but the one at Enfield had not been put together, which would hamper its use in an emergency. There were also pocket life masks, although one had obviously been used and should have been discarded. Custody staff all carried credit card sized certificates confirming that they had received training in resuscitation and use of the defibrillator, but not enough staff were suitably trained in first aid to ensure that there was

always one on duty. There were first aid kits in both suites and staff said new kits were on order to ensure that all were the same for ease of use. The bags were checked weekly by one of the DDOs.

Expectation

- 6.31 Detainees are asked if they wish to see a healthcare professional and are able to request to see one at any time, for both physical and mental health needs.

Findings

- 6.32 Detainees could ask to see a healthcare professional at any point in their detention. The custody officer would request brief details to determine the level of urgency and requests were noted on the custody record along with the time the FME was called. However, custody staff were clear that a detainee would be taken immediately to the nearest accident and emergency department if there was an obvious physical need such as pain or open wounds.
- 6.33 In our survey, 40% of respondents said their entitlement to see a healthcare professional had been explained to them. All the detainees we spoke to had been told they could request to see a doctor and we saw one man doing so some hours after his arrest.
- 6.34 We did not receive any complaints from detainees or staff about current waiting times for the FME. However, FMEs were expected to cover two and sometimes more boroughs during their shift, covering a large geographical area with a high population density. This impacted on response times, which could be unacceptable, varying from 30 minutes to five hours. Reportedly, response times also varied from FME to FME and according to the time of day, although the reason for this had not been determined. If a custody sergeant emailed Forensic Medical Services, who monitored the contracts, about delays then investigations were carried out, but we found little evidence of this occurring.
- 6.35 Most doctors worked a maximum of a 12-hour shift, although we met one doctor who was covering a gap in the rota and had therefore worked for 18 hours. This was poor practice.

Expectation

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

Findings

- 6.37 Any detainee who brought in prescribed medication was seen and assessed by a FME. A note was made in the custody record of any medications assessed as required by the detainee during their time in custody and these were placed in a sealed plastic bag for administration by custody staff. Controlled drugs were administered to detainees directly only by the FME.
- 6.38 When detainees disclosed that they were on a drug withdrawal programme and on regular methadone, steps could be taken to access their prescription from the pharmacy, home or through a family member. However, in general it was reported that this group of detainees would be referred to the FME who might prescribe supportive medication to cover the period in custody.

- 6.39 We met three detainees who admitted to having a drug or alcohol problem, but only one said he had been offered immediate relief for his symptoms. In our survey, 46% of respondents recalled receiving similar relief. Doctors said they did not provide substitute medication, but would provide symptomatic relief on request. There were no policies to this effect.

Expectation

- 6.40 Each detainee seen by healthcare staff has a clinical record containing an up-to-date assessment and any care plan conforms to professional guidance from the regulatory bodies. Ethnicity of the detainees is also recorded.

Findings

- 6.41 Consultations were recorded by all FMEs on NSPIS. Some also used their own notebooks to record more comprehensive notes and some also still used the Book 83 triplicate paper system.
- 6.42 The FME contract emphasised that all clinical records made by the FME remained subject to their physical control and to the normal regulations and statutory provisions governing medical records, as well as the related principles of good medical practice in record-keeping promulgated by the General Medical Council. FMEs were responsible for their retention and secure storage. It was therefore a concern that not all the doctors were aware of their responsibilities regarding the storage and safe custody of clinical information.
- 6.43 On interview, FMEs reported that there were no monitoring or audit arrangements to assess the quality of clinical records. A recent internal inspection by the custody directorate had highlighted that there was no regime for 'dip-sampling' records to check the accuracy of custody record entries.
- 6.44 There were no information-sharing protocols with all appropriate partner agencies to ensure the efficient sharing of relevant health and social care information.

Expectation

- 6.45 Any contact with a doctor or other healthcare professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.

Findings

- 6.46 The notes we saw on the NSPIS system were brief and did not always provide sufficient information, particularly in relation to medications prescribed and administered as the specific prescription part of the medical form on NSPIS was not routinely used.
- 6.47 During the consultations we witnessed, the doctor always made it clear to the patient that the NSPIS record could be viewed by custody staff and others, and in one interview the doctor discussed in some detail with the patient what he would actually record on the system.

- 6.48 Doctors were less clear about whether a detainee could request a copy of their clinical records, including the doctor's own handwritten notes. Most said they would provide a statement if requested by a legal representative with the patient's consent.

Expectation

- 6.49 Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prison drugs workers as appropriate.

Findings

- 6.50 A good person-centred service was provided by the WDP team of drug advisory workers. The team had an office and consultation base at Enfield police station, as well as a community base, and provided a seven day a week advisory and assessment service. Steps were taken to ensure that individual drug health assessments were undertaken confidentially within a safety framework.
- 6.51 All detainees with a positive drug test were automatically referred to the drug advisory team and detailed assessments took place. The detainee received a follow-up appointment in the community before leaving the station and a range of appropriate information and advice as appropriate. There was evidence of good networking with partner organisations, including the community mental health team, housing and social services.
- 6.52 The team had an established practice of 'sweeping' the cells every hour to offer its services to all detainees who expressed a need for an assessment or advice. The team also made contact with the station at Enfield with similar regularity and would also see detainees held there on request.
- 6.53 In order to provide continuity, the original assessor followed up the detainee in the community and was able to offer a number of appointments. There was sufficient flexibility in the team always to ensure that one of its workers was present at Edmonton station between 7am and 10pm on weekdays and on Saturday and Sunday mornings.
- 6.54 There were no similar alcohol services, but detainees could be signposted to supportive community services and given written information and advice.
- 6.55 There was no corresponding drug or alcohol advisory worker service for juveniles. Information and signposting to juvenile services on consent was provided. However, such interviews were conducted through the grille of the cell door and could be overheard by other detainees and staff.

Expectation

- 6.56 A liaison and/or diversion scheme enables detainees with mental health problems to be identified and diverted into appropriate mental health services, or referred on to prison health services.

Findings

- 6.57 There was no liaison/diversion scheme for detainees with mental health problems based in Enfield borough custody suites. This was disappointing as the FMEs talked about the effectiveness of a scheme in a neighbouring borough, provided by Barnet, Enfield and Haringey Mental Health Trust, which also covered the Enfield borough.
- 6.58 There were systems for the referral of detainees to local community mental health teams. Such referrals were undertaken as a result of FME assessment or signposting, or direct appointments were made by drug advisory workers as appropriate.
- 6.59 Where detainees disclosed mental health problems or there was obvious mental health distress, a referral was made promptly to the FME for assessment. Where there were florid symptoms, a referral was made to the crisis intervention team (CIT) for urgent mental health assessment, which took place in the station. The CIT offered a 24-hour service, although response times varied widely.
- 6.60 There could be significant delays between the detainee being received into custody and a referral being made for a mental health assessment. There were a number of inappropriate referrals for a full mental health assessment that could tie up the CIT unnecessarily. There were limited intensive care beds in the area and detainees could be held for long periods in a custody cell while an out-of-borough bed was located.
- 6.61 Mental Health Act and Mental Capacity Act training had not been provided to custody staff or FMEs.
- 6.62 The CIT would on occasions also undertake assessments of juveniles, but mainly these would be undertaken by a consultant child psychiatrist or special registrar.

Expectation

- 6.63 **Police custody is not used as a place of safety for Section 136 assessments except where the detainee needs to be controlled for his or her own safety or the safety of others.**

Findings

- 6.64 There was a dedicated Section 136 suite of high specification within the Barnet, Enfield and Haringey Mental Health Trust site, in Enfield. Detainees were taken there straight from the community by police officers. Effective protocols were in place to release the police officers within an hour to resume their duties subject to the continued safety of the patient. The Section 136 suite was open and staffed 24 hours a day.
- 6.65 The Trust had a comprehensive joint policy with the police for the use of the suite and there were regular liaison meetings between all the parties involved. An inspector based at the Enfield basic command unit was considered to be the 'single point of contact' for Trust staff, which was noted during the liaison meetings to be working well.
- 6.66 Records at the Trust indicated that in the previous six months, an average of five detainees held under Section 136 per month had used the suite, but it had also been used by the police for 'voluntary patients'. Trust staff expressed some concerns that police were picking people

up in the street and bringing them to hospital, but declaring them voluntary patients on arrival and producing no documentation.

Recommendations

- 6.67 Female detainees should be able to see a female doctor on request.
- 6.68 There should be arrangements to support detainees who cannot speak English so that consultations with forensic medical examiners can be conducted in private.
- 6.69 There should be clear lines of accountability and an appraisal system for forensic medical examiners and the contract monitoring should be shared with custody staff.
- 6.70 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development.
- 6.71 Healthcare professionals should have access to basic clinical equipment, such as a glucometer, sphygmomanometer and ophthalmoscope, in the clinical room.
- 6.72 There should be clear infection control procedures, including cleaning schedules, that should be adhered to and monitored.
- 6.73 All custody staff and healthcare professionals should have the newly introduced guidelines for the security, management, administration and disposal of drugs and medicines in custody reiterated to them and these should be followed. There should be audits of compliance.
- 6.74 Detainees should continue to receive prescribed medication for any clinical condition, and receive medication to provide relief for drug and alcohol withdrawal symptoms, if needed.
- 6.75 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance.
- 6.76 To ensure response times are acceptable, forensic medical examiners should not be expected to cover such a large geographical area.
- 6.77 Any contact with a doctor or other healthcare professional should be recorded in the custody record and a clear record made of any medication prescribed and administered.
- 6.78 Detainees should be able to obtain the results of any clinical examinations.
- 6.79 All detainees, including juveniles, should be offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prison drugs workers as appropriate.
- 6.80 There should be a liaison/diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services.

Housekeeping points

- 6.81 There should be screens around examination couches to provide privacy.
- 6.82 The clinical room at Enfield should be of an ambient temperature.
- 6.83 All clinical waste, including sharps, should be managed and disposed of correctly.
- 6.84 Fridges should be defrosted regularly.
- 6.85 Forensic sampling kits should be subject to stock rotation.
- 6.86 All resuscitation equipment should be clean and ready for use.
- 6.87 The defibrillator pads should be checked when the automated external defibrillator is checked to ensure that they are in date.

Good practice

- 6.88 *The Barnet, Enfield and Haringey Mental Health Trust had a comprehensive joint policy with the police for the use of the suite and there were regular liaison meetings between all the parties involved. An inspector based at the Enfield basic command unit was considered to be the 'single point of contact' for Trust staff, which was noted during the liaison meetings to be working well.*

7. Summary of recommendations

Strategy

To the Metropolitan Police Service

- 7.1 To ensure the implementation of corporate policies and the maintenance of corporate standards, the Metropolitan Police Service should consider putting the management of all custody suites under one operational command unit. (3.16)
- 7.2 Police officers and staff should access the 'lessons learned' circular from the Independent Police Complaints Commission. (3.17)
- 7.3 Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated. (3.18)
- 7.4 The number and nature of complaints should be collated and analysed centrally with a view to feeding management information back to borough commanders and custody managers so the underlying cause of complaints can be identified with a view to problem solving these issues. (3.19)
- 7.5 Consideration should be given by the Metropolitan Police Service to providing boroughs centrally with fridges and freezers that are of an industrial standard. (3.20)
- 7.6 The ongoing issues within the Metropolitan Police Service surrounding the taking, storing and submission of DNA and forensic samples should be addressed as an urgent priority, including a referral to the forensic science regulator. (3.21)
- 7.7 The breath test machines should be positioned so that investigation procedures can be carried out in private. (3.22)

To the Metropolitan Police Authority

- 7.8 The Metropolitan Police Authority should allocate one authority member as lead for custody. (3.23)

Treatment and conditions

- 7.9 Fire training should be given to all custody staff and fire evacuation drills practised regularly. A notice setting out the actions to take in the event of a fire or evacuation should be posted in custody suites. (4.62)
- 7.10 Custody officers should explain what 'other detention related issues' covers so that detainees are clearer about the question and its relevance to their circumstances and needs. (4.63)
- 7.11 Detainees should be offered an appropriate level of privacy when being booked in and when making or receiving a telephone call at the front desk. (4.64)

- 7.12 Custody sergeants should have a good understanding of the safer custody handling procedures, particularly in relation to incidents of suicide and self-harm. (4.65)
- 7.13 A policy for the management of vulnerable juvenile detainees should be developed, implemented and consistently applied. (4.66)
- 7.14 The appropriateness of strip searching of detainees should be monitored locally when dip sampling records. (4.67)
- 7.15 The use of cell bells should routinely be explained to detainees, and detainees should particularly be informed that they need to use the call bell to ask for toilet tissue and to use the wash basin. (4.68)
- 7.16 Adapted cells should be available for use by detainees with a disability. (4.69)
- 7.17 Furniture in interview and consultation rooms that could be used as weapons should be bolted to the floor. (4.70)
- 7.18 Female detainees should routinely be told that hygiene packs are available and how they can be accessed. (4.71)
- 7.19 The holding areas in custody suites should display information about services available to them. (4.72)
- 7.20 On an individually assessed basis, nicotine replacement should be available to smokers. (4.73)
- 7.21 A range of age-appropriate reading material, including some in relevant languages other than English, should be provided and detainees told that this is available. (4.74)
- 7.22 A force-wide custody policy to address graffiti should be developed and graffiti should be properly removed from all cells. (4.75)
- 7.23 Detainees should be offered a shower, particularly if they are held for 24 hours. (4.76)
- 7.24 Towels should be provided to detainees who want to take a shower. (4.77)
- 7.25 Detainees should be offered regular meals and drinks and this should be recorded in custody records even when refreshment is refused. (4.78)
- 7.26 The toilets at Edmonton should be screened. (4.79)
- 7.27 Toilet paper should be provided in cells. (4.80)
- 7.28 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air. (4.81)
- 7.29 A range of age-appropriate reading material, including some in relevant languages other than English, should be provided and detainees told that this is available. (4.82)
- 7.30 Visits should be allowed for those detained more than 24 hours and for young people. (4.83)

Individual rights

- 7.31 Appropriate adults should be allowed to wait with juveniles in the custody suite. (5.43)
- 7.32 Detainees aged 17 years should be provided with an appropriate adult. (5.44)
- 7.33 All custody staff should receive specialist training in the care of children and young people and all policies should reflect their particular needs. (5.45)
- 7.34 Staff should undergo enhanced Criminal Records Bureau checks for working in the custody suite. (5.46)
- 7.35 Custody staff should consider the need to avoid delays for detainees taken into custody during the night and make arrangements for interviews to take place within a reasonable time. (5.47)
- 7.36 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites. (5.48)
- 7.37 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.49)
- 7.38 The pre-release risk management policy should be implemented consistently, particularly for vulnerable and young people, with actions taken recorded on NSPIS. Custody staff should receive training in this process. (5.50)

Healthcare

- 7.39 Female detainees should be able to see a female doctor on request. (6.67)
- 7.40 There should be arrangements to support detainees who cannot speak English so that consultations with forensic medical examiners can be conducted in private. (6.68)
- 7.41 There should be clear lines of accountability and an appraisal system for forensic medical examiners and the contract monitoring should be shared with custody staff. (6.69)
- 7.42 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development. (6.70)
- 7.43 Healthcare professionals should have access to basic clinical equipment, such as a glucometer, sphygmomanometer and ophthalmoscope, in the clinical room. (6.71)
- 7.44 There should be clear infection control procedures, including cleaning schedules, that should be adhered to and monitored. (6.72)
- 7.45 All custody staff and healthcare professionals should have the newly introduced guidelines for the security, management, administration and disposal of drugs and medicines in custody reiterated to them and these should be followed. There should be audits of compliance. (6.73)

- 7.46 Detainees should continue to receive prescribed medication for any clinical condition, and receive medication to provide relief for drug and alcohol withdrawal symptoms, if needed. (6.74)
- 7.47 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance. (6.75)
- 7.48 To ensure response times are acceptable, forensic medical examiners should not be expected to cover such a large geographical area. (6.76)
- 7.49 Any contact with a doctor or other healthcare professional should be recorded in the custody record and a clear record made of any medication prescribed and administered. (6.77)
- 7.50 Detainees should be able to obtain the results of any clinical examinations. (6.78)
- 7.51 All detainees, including juveniles, should be offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prison drugs workers as appropriate. (6.79)
- 7.52 There should be a liaison/diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services. (6.80)

Housekeeping points

Healthcare

- 7.53 There should be screens around examination couches to provide privacy. (6.81)
- 7.54 The clinical room at Enfield should be of an ambient temperature. (6.82)
- 7.55 All clinical waste, including sharps, should be managed and disposed of correctly. (6.83)
- 7.56 Fridges should be defrosted regularly. (6.84)
- 7.57 Forensic sampling kits should be subject to stock rotation. (6.85)
- 7.58 All resuscitation equipment should be clean and ready for use. (6.86)
- 7.59 The defibrillator pads should be checked when the automated external defibrillator is checked to ensure that they are in date. (6.87)

Good practice

Strategy

- 7.60 A tri-borough approach to mental health matters involving the boroughs of Haringey, Barnet and Enfield had begun in February 2009. All three boroughs had given up some staff to ensure this collaborative approach was a success and this innovative partnership arrangement worked commendably well. (3.24)

Healthcare

- 7.61 The Barnet, Enfield and Haringey Mental Health Trust had a comprehensive joint policy with the police for the use of the suite and there were regular liaison meetings between all the parties involved. An inspector based at the Enfield basic command unit was considered to be the 'single point of contact' for Trust staff, which was noted during the liaison meetings to be working well. (6.88)

Appendix I : Inspection team

Sara Snell	Team leader HMI Prisons
Paddy Craig	HMI Constabulary
Sean Sullivan	HMI Prisons
Vinnett Percy	HMI Prisons
Karen Dillon	HMI Prisons
Anita Saigal	HMI Prisons
Elizabeth Tysoe	Head of healthcare inspection, HMI Prisons
Marilyn Hansford	Care Quality Commission Inspector
Samantha Booth	Senior researcher, HMI Prisons

Appendix II: Custody Record Analysis

Background

As part of the inspection of Enfield Borough police custody cells, a sample of the custody records of detainees held between 15 April and 13 May 2009 was analysed. Custody records were held electronically on NSPIS. A sample of 42 records was analysed from across the Enfield area:

Custody suite	Number of records analysed
Edmonton	30
Enfield	12
Total	42

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

Demographic information

- Five (12%) of the detainees were female and 37 were male.
- Five people (12%) under the age of 17 were included in the sample.
- 27 (64%) detainees were white European and 15 were from a black and minority ethnic background.
- 16 (38%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. Three (7%) had been held for more than 24 hours.

Removal of clothing

Two detainees had had clothing removed from them:

- One detainee had had their outer clothing removed.
- One detainee had had all clothes removed and had been given 'appropriate clothing'.

Young people

Appropriate adults had been requested for all five of the young people in our sample. For four of the cases, appropriate adults had attended and sat in on interviews. For the other young person, an appropriate adult had been requested, but charges were dropped and the young person released without interview so the appropriate adult was not used.

One young person with no English was unsure of his exact address. As he were released late at night, officers and an interpreter drove him back home to ensure he got back safely.

Interpreters

Nine (21%) detainees in our sample could not understand English and required an interpreter. Interpreters were requested and attended. In two cases, a telephone interpreting service was used in the interim before an interpreter arrived.

Immigration detainees

Two of our sample were immigration detainees:

- In one case, the detainee arrived in the morning and an immigration officer arrived within four hours to conduct an interview and serve an IS91. The detainee was held about 37 hours until they were released to immigration.
- The other detainee arrived early evening and custody staff called immigration and were told that they would call back in the morning. When they called in the morning, the detainee was released as they had been given leave to remain for a longer period. The detainee was held about 16 hours while this was clarified by immigration.

Inspector reviews

Inspector reviews were held in line with requirements. A few reviews were conducted at a delayed time due to other operational commitments.

Services

- All detainees had been asked whether they wanted someone informed of their arrest. Ten (24%) detainees had made additional telephone calls.
- All detainees had been asked if they wanted a solicitor. Fourteen (33%) had requested a solicitor and spoken to/seen either their solicitor or a duty solicitor.
- No detainees shared a cell in custody.
- Sixteen (38%) detainees had requested to see the FME and 14 of these had seen the FME. The longest wait was three hours 20 minutes where the FME had arrived via another station and custody staff had called to chase up to find out an estimated arrival time. The two detainees who were not seen by the FME were released before they were able to. In one case, the female detainee had requested to see the FME as she felt dizzy and had stomach pains. She was released three hours later without having seen the FME having spent most of that time being interviewed.
- Two detainees had seen a drugs worker. In one case, the detainee had requested to see an alcohol worker, but as this service was not available was seen by a drugs worker instead.
- Fourteen (33%) detainees had eaten at least one meal in custody. Another three had been offered food but refused. There were some examples of detainees being released in the morning having been held overnight with no offer of breakfast recorded, or arriving just after dinnertime and again an evening meal not being recorded as even offered. One detainee was held for about 47 hours with only one meal received; there was no mention of meals having been offered and refused.
- Two detainees had received a 'wash', but no detainees had received a shower.
- No detainees had received outside exercise.
- No detainees had been provided with reading materials.

Additional points of note

- NSPIS automatically prompted staff to check whether females arriving into custody wanted to speak to a female member of staff in private.
- The foreign nationals rights procedure was conducted with foreign national detainees.

Appendix III: Summary of detainee questionnaires and interviews

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Enfield, was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection write-up.

Choosing the sample size

The survey was conducted on 12 May 2009. A list of potential prisoners, who had been through Enfield police station, was created listing those from Enfield Magistrates court.

Selecting the sample

32 prisoners in total were approached. 11 prisoners reported being held in police stations outside of Enfield. On the day, the questionnaire was given to 21 prisoners, with none of them refusing to take a survey. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Two prisoners had language difficulties and two could not read or write and so they were interviewed.

Methodology

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

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

- to fill out the questionnaire immediately and hand it straight back to a member of the research team;
- have their questionnaire ready to hand back to a member of the research team at a specified time; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 21 (100%) respondents completed and returned their questionnaires.

Police Custody Survey

Section 1: About You

Q2	What police station were you last held at?		
		Unrecorded, 2; Edmonton 17; Enfield 2	
Q3	What type of detainee were you?		
	Police detainee.....		16
	Prison lock-out (i.e. you were in custody in a prison before coming here).....		2
	Immigration detainee.....		0
	I don't know.....		2
Q4	How old are you?		
	16 years or younger.....	0	40-49 years..... 0
	17-21 years.....	1	50-59 years..... 1
	22-29 years.....	11	60 years or older..... 0
	30-39 years.....	8	
Q5	Are you:		
	Male.....		21
	Female.....		0
	Transgender/Transsexual.....		0
Q6	What is your ethnic origin?		
	White - British.....		4
	White - Irish.....		1
	White - Other.....		5
	Black or Black British - Caribbean.....		7
	Black or Black British - African.....		1
	Black or Black British - Other.....		0
	Asian or Asian British - Indian.....		0
	Asian or Asian British - Pakistani.....		0
	Asian or Asian British - Bangladeshi.....		0
	Asian or Asian British - Other.....		0
	Mixed Race - White and Black Caribbean.....		1
	Mixed Race - White and Black African.....		1
	Mixed Race - White and Asian.....		0
	Mixed Race - Other.....		0
	Chinese.....		0
	Other ethnic group.....		1
Q7	Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?		
	Yes.....		5
	No.....		14
Q8	What, if any, would you classify as your religious group?		
	None.....		1
	Church of England.....		7
	Catholic.....		8
	Protestant.....		0
	Other Christian denomination.....		2
	Buddhist.....		0
	Hindu.....		0
	Jewish.....		0
	Muslim.....		3
	Sikh.....		0

Q9	How would you describe your sexual orientation?	
	<i>Straight / Heterosexual</i>	21
	<i>Gay / Lesbian / Homosexual</i>	0
	<i>Bisexual</i>	0
Q10	Do you consider yourself to have a disability?	
	<i>Yes</i>	2
	<i>No</i>	17
	<i>Don't know</i>	2
Q11	Have you ever been held in police custody before?	
	<i>Yes</i>	19
	<i>No</i>	2

Section 2: Your experience of this custody suite

If you were a 'prison-lock out' **some** of the following questions may not apply to you.
If a question does not apply to you, please leave it blank.

Q12	How long were you held at the police station?	
	<i>1 hour or less</i>	0
	<i>More than 1 hour, but less than 6 hours</i>	1
	<i>More than 6 hours, but less than 12 hours</i>	1
	<i>More than 12 hours, but less than 24 hours</i>	2
	<i>More than 24 hours, but less than 48 hours (2 days)</i>	7
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i>	5
	<i>72 hours (3 days) or more</i>	4
Q13	Were you given information about your arrest and your entitlements when you arrived there?	
	<i>Yes</i>	14
	<i>No</i>	4
	<i>Don't know/Can't remember</i>	2
Q14	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?	
	<i>Yes</i>	5
	<i>No</i>	7
	<i>I don't know what this is/I don't remember</i>	8
Q15	If your clothes were taken away, were you offered different clothing to wear?	
	<i>My clothes were not taken</i>	12
	<i>I was offered a tracksuit to wear</i>	4
	<i>I was offered an evidence suit to wear</i>	2
	<i>I was offered a blanket</i>	0
Q16	Could you use a toilet when you needed to?	
	<i>Yes</i>	16
	<i>No</i>	4
	<i>Don't know</i>	0
Q17	If you have used the toilet there, were these things provided?	
	Yes	No
	<i>Toilet paper</i>	10
		10
Q18	Did you share a cell at the police station?	
	<i>Yes</i>	0
	<i>No</i>	20

Q19	How would you rate the condition of your cell:			
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>
	Cleanliness	5	6	10
	Ventilation / Air Quality	3	9	8
	Temperature	0	7	13
	Lighting	8	8	4
Q20	Was there any graffiti in your cell when you arrived?			
	Yes.....			16
	No.....			5
Q21	Did staff explain to you the correct use of the cell bell?			
	Yes.....			4
	No.....			16
Q22	Were you held overnight?			
	Yes.....			19
	No.....			1
Q23	If you were held overnight, which items of clean bedding were you given?			
	<i>Not held overnight</i>			1
	<i>Pillow</i>			6
	<i>Blanket</i>			5
	<i>Nothing</i>			11
Q24	Were you offered a shower at the police station?			
	Yes.....			1
	No.....			20
Q25	Were you offered any period of outside exercise while there?			
	Yes.....			0
	No.....			19
Q26	Were you offered anything to:			
		<i>Yes</i>		<i>No</i>
	Eat?	14		7
	Drink?	15		4
Q27	Was the food/drink you received suitable for your dietary requirements?			
	<i>I did not have any food or drink</i>			4
	Yes.....			9
	No.....			6
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?			
	<i>I do not smoke</i>			5
	<i>I was allowed to smoke</i>			1
	<i>I was not offered anything to cope with not smoking</i>			14
	<i>I was offered nicotine gum</i>			0
	<i>I was offered nicotine patches</i>			0
	<i>I was offered nicotine lozenges</i>			0
Q29	Were you offered anything to read?			
	Yes.....			0
	No.....			20
Q30	Was someone informed of your arrest?			
	Yes.....			7
	No.....			10
	<i>I don't know</i>			2
	<i>I didn't want to inform anyone</i>			1

Q31	Were you offered a free telephone call?			
	Yes			9
	No.....			11
Q32	If you were denied a free phone call, was a reason for this offered?			
	<i>My phone call was not denied</i>			9
	Yes.....			1
	No.....			7
Q33	Did you have any concerns about the following, while you were in police custody:			
		Yes	No	
	Who was taking care of your children	5	8	
	Contacting your partner, relative or friend	9	5	
	Contacting your employer	7	7	
	Where you were going once released	7	7	
Q34	Were you interviewed by police officials about your case?			
	Yes			18
	No.....			2
Q35	Were any of the following people present when you were interviewed?			
		Yes	No	Not needed
	Solicitor	13	4	1
	Appropriate adult	0	1	9
	Interpreter	3	1	9
Q36	How long did you have to wait for your solicitor?			
	<i>I did not request a solicitor</i>			4
	<i>2 hours or less</i>			3
	<i>Over 2 hours but less than 4 hours</i>			3
	<i>4 hours or more</i>			10
Q37	Were you officially charged?			
	Yes.....			17
	No.....			3
	<i>Don't know</i>			1
Q38	How long were you in police custody <i>after</i> being charged?			
	<i>I have not been charged yet</i>			3
	<i>1 hour or less</i>			1
	<i>More than 1 hour, but less than 6 hours</i>			0
	<i>More than 6 hours, but less than 12 hours</i>			2
	<i>12 hours or more</i>			13

Section 3: Safety

Q40	Did you feel safe there?			
	Yes		11	
	No.....		9	
Q41	Had another detainee or a member of staff victimised (insulted or assaulted) you there?			
	Yes	13		
	No.....	7		
Q42	If you have felt victimised, what did the incident involve? (Please tick all that apply)			
	<i>I have not been victimised</i>	7	<i>Because of your crime</i>	4
	<i>Insulting remarks (about you, your family or friends)</i> ..	5	<i>Because of your sexuality</i>	0
	<i>Physical abuse (being hit, kicked or assaulted)</i>	3	<i>Because you have a disability</i>	0

Sexual abuse.....	0	Because of your religion/religious beliefs.....	0
Your race or ethnic origin	2	Because you are from a different part of the country than others.....	3
Drugs.....	5		

Q43 Were you handcuffed or restrained while in the police custody suite?
 Yes..... 13
 No..... 7

Q44 Were you injured while in police custody, in a way that you feel was not your fault?
 Yes..... 7
 No..... 13

Q45 Were you told how to make a complaint about your treatment here, if you needed to?
 Yes..... 0
 No..... 20

Section 4: Healthcare

Q47 When you were in police custody were you on any medication?
 Yes..... 6
 No..... 15

Q48 Were you able to continue taking your medication while there?
 Not taking medication..... 15
 Yes..... 3
 No..... 2

Q49 Did someone explain your entitlements to see a healthcare professional, if you needed to?
 Yes..... 8
 No..... 10
 Don't know..... 2

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

	Yes	No
Doctor	12	9
Nurse	0	16
Paramedic	0	16
Psychiatrist	0	16

Q51 Were you able to see a healthcare professional of your own gender?
 Yes..... 9
 No..... 9
 Don't know..... 3

Q52 Did you have any drug or alcohol problems?
 Yes..... 11
 No..... 10

Q53 Did you see, or were offered the chance to see a drug or alcohol support worker?
 I didn't have any drug/alcohol problems 10
 Yes..... 7
 No..... 4

Q54 Were you offered relief or medication for your immediate symptoms?
 I didn't have any drug/alcohol problems 10
 Yes..... 5
 No..... 6

Q55	Please rate the quality of your healthcare while in police custody:						
		I was not seen by healthcare	<i>Very Good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>
	Quality of healthcare	9	3	3	2	2	1
Q56	Did you have any specific <u>physical</u> healthcare needs?						
	No.....						14
	Yes.....						5
Q57	Did you have any specific <u>mental</u> healthcare needs?						
	No.....						17
	Yes.....						3



Prisoner Survey Responses for Enfield Police 2009

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

Key to tables

		Enfield	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		21	302
SECTION 1: General Information			
2	Are you a Police detainee?	79%	85%
3	Are you under 21 years of age?	4%	11%
4	Are you Transgender/Transsexual?	0%	1%
5	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories)	52%	32%
6	Are you a foreign national?	27%	15%
7	Are you Muslim?	14%	10%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	10%	17%
10	Have you been in police custody before?	90%	89%
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24hours?	79%	64%
12	Were you given information about your arrest and entitlements when you arrived?	70%	73%
13	Were you told about PACE?	25%	58%
14	If your clothes were taken away, were you given a tracksuit to wear?	67%	38%
15	Could you use a toilet when you needed to?	79%	88%
16	If you did use the toilet, was toilet paper provided?	50%	55%
17	Did you share a cell at the station?	0%	4%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	24%	25%
18b	Ventilation/air quality?	15%	18%
18c	Temperature?	0%	13%
18d	Lighting?	40%	43%
19	Was there any graffiti in your cell when you arrived?	76%	56%
20	Did staff explain the correct use of the cell bell?	21%	23%
21	Were you held overnight?	96%	89%
22	If you were held overnight, were you given no clean items of bedding?	55%	32%
23	Were you offered a shower?	4%	9%

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24	Were you offered a period of outside exercise?	0%	7%
25a	Were you offered anything to eat?	66%	76%
25b	Were you offered anything to drink?	78%	81%
26	Was the food/drink you received suitable for your dietary requirements?	60%	38%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	70%	78%
28	Were you offered anything to read?	0%	14%
29	Was someone informed of your arrest?	35%	44%
30	Were you offered a free telephone call?	45%	49%
31	If you were denied a free call, was a reason given?	11%	21%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	39%	19%
32b	Contacting your partner, relative or friend?	64%	56%
32c	Contacting your employer?	50%	22%
32d	Where you were going once released?	50%	36%
34	If you were interviewed were the following people present:		
34a	Solicitor	72%	73%
34b	Appropriate adult	0%	6%
34c	Interpreter	23%	7%
35	Did you wait over 4 hours for your solicitor?	63%	65%
37	Were you held 12 hours or more in custody after being charged?	82%	64%

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SECTION 3: Safety			
39	Did you feel unsafe?	45%	41%
40	Has another detainee or a member of staff victimised you?	65%	41%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	25%	27%
41b	Physical abuse (being hit, kicked or assaulted)	15%	17%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	10%	6%
41e	Drugs	25%	16%
41f	Because of your crime	21%	21%
41g	Because of your sexuality	0%	0%
41h	Because you have a disability	0%	4%
41i	Because of your religion/religious beliefs	0%	3%
41j	Because you are from a different part of the country than others	15%	4%
42	Were you handcuffed or restrained whilst in the police custody suite?	65%	49%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	35%	30%
44	Were you told how to make a complaint about your treatment?	0%	14%

Key to tables

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SECTION 4: Healthcare			
46	Were you on any medication?	28%	47%
47	For those who were on medication: were you able to continue taking your medication?	58%	37%
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	40%	36%
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	58%	50%
49b	Nurse	0%	21%
49c	Paramedic	0%	3%
49d	Psychiatrist	0%	4%
50	Were you able to see a healthcare professional of your own gender?	42%	27%
51	Did you have any drug or alcohol problems?	52%	58%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	63%	38%
53	Were you offered relief medication for your immediate symptoms?	46%	31%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	54%	27%
55	Do you have any specific physical healthcare needs?	27%	37%
56	Do you have any specific mental healthcare needs?	15%	24%