



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

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by

HM Inspectorate of Prisons and

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Contents

1. Introduction	5
2. Background and key findings	7
3. Strategy	11
4. Treatment and conditions	15
5. Individual rights	19
6. Healthcare	25
7. Summary of recommendations	33

Appendices

I Inspection team	39
II Custody record analysis	40
III Prisoner police custody survey	43

1. Introduction

This inspection of police custody suites in the London Borough of Tower Hamlets 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. The programme is a mix of announced and unannounced inspections. This was the first of these inspections to be carried out without prior notice.

There were two custody suites in the basic command unit: the main suite at Bethnal Green and a smaller one at Limehouse. There was good senior management oversight of custody, through the Operation Emerald commander, the borough commander and a custody manager, who was an inspector. However, the temporary custody officers who staffed the custody suites were not line-managed by the custody manager, which reduced opportunities for training and information-sharing. As we have found in other suites, there were no central mechanisms for collating and drawing management information from complaints or incidents where force is used.

We found that detainees were treated well in both suites, but we were concerned by weaknesses in the appropriate adult scheme for juveniles and vulnerable adults. There was considerable confusion and delay, especially at Limehouse. As we have found in other inspections, 17 year olds, who are legally children, were not treated as such, and in one case we found insufficient understanding of statutory child protection requirements. It was welcome, however, that there was a new triage system coordinated by the youth offending team aimed at diverting juveniles from the criminal justice system.

Conditions at Bethnal Green were good, but those in the Limehouse suite were unsatisfactory. Necessities were not automatically provided, cells were not routinely cleaned between occupants and paper suits, rather than track suits, were usually offered to detainees whose clothing had been removed.

Detainees' legal rights, and access to legal advice, were respected. However, there was considerable confusion about the complaints system and in one case a detainee had been unable to make a complaint about an alleged assault. The management of DNA and forensic samples remained of concern, as at a number of other custody suites inspected.

A new forensic medical examiner (FME) contract was in place, but arrangements for monitoring its delivery were unclear. There could be significant delays before an FME arrived, and consultations were not always confidential, and sometimes very short. There was some confusion among staff about mental health services available, but there were good drug and alcohol services, with a range of interventions.

Inspections within the Metropolitan Police Service have shown much good practice, but have also revealed some consistent themes that need management attention. This inspection revealed much to commend, and we have been pleased by the readiness of senior officers to

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

use our findings to improve provision. We hope that the recommendations in this report will assist them in doing so.

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HM Chief Inspector of Constabulary

Anne Owers
HM Chief Inspector of Prisons

October 2009

2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the guidance on safer detention and handling of persons in police custody, and focus on outcomes for detainees. They are informed by a set of expectations about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.
- 2.2 The Metropolitan Police Service (MPS) has 77 custody suites designated under the 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 is used for Operation Safeguard (overflow from prisons) when needed. The remaining 51 custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.
- 2.3 This unannounced inspection was conducted at Bethnal Green and Limehouse custody suites in the London Borough of Tower Hamlets. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and healthcare in the two suites. A survey of prisoners at HMP Brixton who had formerly been detained in Bethnal Green and Limehouse custody suites was conducted by HM Inspectorate of Prisons researchers and an HM Inspectorate of Constabulary staff officer to obtain additional evidence (see appendix III).
- 2.4 Bethnal Green and Limehouse custody suites were open 24 hours a day and held adults and juveniles. The suites had received 5,606 detainees in the six months to 30 April 2009 (4,050 at Bethnal Green and 1,274 at Limehouse). Ninety-six immigration detainees had been held in the year to April 2009, mainly at Bethnal Green.

Strategic overview

- 2.5 The MPS custody directorate within the Operation Emerald territorial policing team had strategic oversight of custody in all boroughs in London. This was led by a commander, with day-to-day management delivered by a detective superintendent. The custody directorate had an internal inspection function, which focused mainly on adherence to the PACE codes of practice, and safer detention and handling of persons in police custody (SDHP) guidance (2006). 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 (ICV) scheme and had by default taken the lead responsibility for reporting on custody issues. The borough was responsive to issues raised by ICVs. There was also a MPA member-led panel that reviewed and led on the custody suite building programme.

- 2.7 Custody was managed by a chief inspector, who reported to the assistant borough commander, and a full-time custody manager, who was an inspector. The custody manager was responsible for ensuring that all procedures and practices dictated by Emerald were in place and had oversight of custody at Bethnal Green and Limehouse. This included carrying out a 10% dip-sample of custody records. A duty PACE inspector also provided day-to-day management and detention reviews for detainees held at both sites.
- 2.8 The staffing model at both custody suites used temporary custody officers drawn from a pool of 36 patrol team custody trained sergeants. These staff were managed through their operational line rather than by the custody manager, which restricted the opportunity to provide regular off-the-job refresher training. Custody officers were supported by designated detention officers (DDOs) and police constable (PC) gaolers. DDOs were managed by the custody manager. The custody manager was cascading Independent Police Complaints Commission (IPCC) lessons learned information, but some staff were not aware of these.
- 2.9 Not enough was done to develop positive partnership work with local mental health providers and the appropriate adult scheme was not functioning properly. There was an excellent drug referral scheme and a pilot scheme to work with juveniles. Plans were advanced to introduce on-site nurse practitioners at both custody suites. Relationships with the Crown Prosecution Service (CPS) were good.
- 2.10 There was no strategic steer on the use of force and no management information was collected to enable senior management monitoring and oversight. Similarly, the information available from complaints was not used to inform practice.

Treatment and conditions

- 2.11 Detainees were mostly treated respectfully and custody staff dealt positively with some complex and challenging situations. Both sites had allocated detention rooms for women and juveniles, but otherwise they were not treated differently to male detainees. No cells were adapted for use by detainees with disabilities. Many detainees did not speak English and professional telephone interpreting services were frequently used for booking in. General interpreters were regularly used for more formal police interviews. A new triage system coordinated by the youth offending team (YOT) aimed to divert juveniles away from the criminal justice system.
- 2.12 Risk assessments were completed on arrival and some, but not all, were subsequently changed to reflect new information. All staff carried anti-ligature knives. Custody officers were not offered off-the-job refresher training. The use of cell call bells was not routinely explained to detainees. Uses of force were noted on custody records and the evidence log, but there was no central recording or separate account made for monitoring. Custody records reviewed did not indicate that force was over-used.
- 2.13 Bethnal Green was relatively clean and well presented, but the cells at Limehouse were dirty and contained a lot of graffiti. There were a number of other failings at Limehouse. Cells were not routinely cleaned between occupants. The flooring was particularly poor and the pillows were not routinely cleaned after use. Blankets had to be requested, as did toilet paper and hygiene packs for women. Few detainees were offered showers and then only on request. Only paper towels were available and the single shower offered little privacy. Paper suits were usually offered instead of track suits to detainees whose clothing had been removed. Both suites enforced a no smoking policy, but smokers were not offered nicotine replacements.

- 2.14 A good range of meal options included halal, vegetarian and vegan. Outside exercise areas were rarely, if ever, used. Detainees at Limehouse were not offered anything to read and neither suite facilitated visits.

Individual rights

- 2.15 Some custody reviews were completed without the detainee being seen by an inspector and a number of custody records were poorly completed with contradictory entries. Children and young people held under section 46 of the Children Act 1989 were brought to the stations, but staff said they were not brought into the custody suite. Immigration detainees were usually held at Bethnal Green and staff gave some examples of delays in moving them on. The lack of a clear procedure to help those with dependency obligations resulted in an inconsistent approach. A new pre-release planning system for vulnerable detainees had been introduced and was used, but this was often not reflected in custody records.
- 2.16 There was no clearly defined or effective appropriate adult scheme. Staff, particularly at Limehouse, were unclear about whether such a scheme still operated and, even when appropriate adults could be contacted, they would often not attend until a solicitor had arrived. 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.
- 2.17 The duty solicitor scheme worked well, but specific immigration legal advice was not available. Detainees were not interviewed while under the influence of substances. The official court cut-off time was 1pm, but places were sometimes refused much earlier when courts said they were full.
- 2.18 The management of DNA and forensic samples was a concern and a number of police officers seemed confused about when to take DNA samples, where to store them and what to do with them subsequently. We found a number of samples of DNA that had not been submitted for inclusion on the national DNA database and not all forensic exhibits were properly bagged, labelled and managed. In contrast, the DDOs were very clear about their role and responsibilities and effectively managed their DNA samples.
- 2.19 Staff and detainees were confused about the complaints system. Staff said detainees were routinely told to make formal complaints at the front desk on release, while managers said more serious issues would be dealt with by the reviewing inspector. We came across a case of alleged assault where the detainee had been unable to make a formal complaint. Detainees were regularly strip searched, but custody records often did not make clear why it had been necessary.

Healthcare

- 2.20 There was a new forensic medical examiner (FME) rota, but nothing in terms of training, supervision, accountability and appraisal. Some FMEs were comfortable with the role, but locum FMEs were used to fill gaps and some were not national strategy for police information systems (NSPIS) trained or familiar with custody. It could take as long as four hours for an FME to arrive after being called and consultations were often brief. Medical room doors were left open during clinical examinations, with DDOs and gaolers in the room with no good reason. There was no access to a telephone interpreting service from FME rooms.
- 2.21 FME rooms were not clinically clean or capable of being forensically cleaned. Drug management arrangements were poor and some controlled drugs were not securely locked

away. Limited medical equipment was available, but FMEs brought their own and supplied their own prescribed drugs.

2.22 New detainees were routinely asked if they wanted to see an FME, but FMEs were not telephoned to establish whether prescribed medication could be given in cell. Record-keeping was poor.

2.23 On-site local authority-funded drug intervention programme workers at Bethnal Green saw detainees with trigger offences and those with alcohol problems. A good range of interventions was offered to those in scope of the service. The service was advertised as also available at Limehouse, but this appeared to happen infrequently.

2.24 Custody was not used for Section 136 (place of safety) detainees except for those deemed to be violent or drunk, but the 60 referrals made in the previous year appeared very low. Four separate community mental health teams operated in the borough, adding to staff confusion about what services were available and how to access them. Custody sergeants reported poor responses when trying to bring in specialist support.

3. Strategy

Expected outcomes:

There is a strategic focus on custody that drives the development and application of custody specific policies and procedures to protect the wellbeing of detainees.

- 3.1 The MPS had a custody directorate within the Operation Emerald Territorial Policing Team 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. There was no defined MPA lead for custody, but a MPA official managed the Independent Custody Visitors (ICVs) scheme and had lead responsibility for reporting on custody issues. Relationships with ICVs were good. Custody sergeants were not permanent and some staff had not received enough training. There was no identifiable feedback process to boroughs or custody managers about complaints. A MPA member-led panel reviewed and led on the custody suite building programme. The MPS's asset management plan was stalled due to the wider economic situation.
- 3.2 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.
- 3.3 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, such as use of police custody, use of closed-circuit television and guidance to custody staff on the supervision of detainees. The SOPs were designed to assist boroughs to deliver consistent levels of service, although responsibility and accountability for their delivery had been delegated to borough commanders.
- 3.4 The MPS had recruited its first team of nurses to complement the level of healthcare provided by doctors. It was looking to recruit 200 nurses by 2012, with a view to ensuring each borough had an on-duty nurse 24 hours a day. The issue of clinical governance was being revisited with a view to employing a member of staff full time.
- 3.5 Apart from the borough commander, the senior management team (SMT) was relatively new and none had been in post for longer than eight weeks. The responsible detective superintendent took up his post on the first day of the inspection. The SMT lead for custody was the patrol chief inspector, who line managed the custody manager (an inspector).
- 3.6 Tower Hamlets borough has two custody suites, Bethnal Green and Limehouse. Bethnal Green is the main custody suite, with 14 cells and four detention rooms, one of which had been converted into a consultation room. A subsidiary unit at Limehouse had five cells and one detention room. It was used for dealing with detainees for the Violent Crime Unit, the Sexual Offences Unit (Sapphire Unit) and the Community Safety Team (domestic violence).

- 3.7 The borough had two inspectors on duty at any one time, one of whom was the duty officer who dealt with critical incidents. The other inspector was the support inspector and they were responsible for managing the custody suites, among other duties. They carried out the police and criminal evidence (PACE) reviews of detainees, handled any custody issues and ensured that prisoners were dealt with appropriately. The custody manager was responsible for both custody suites and he had line manager responsibilities for the designated detention officers (DDOs), the bailed to return (BTR) sergeants and the DDO manager. He did not have line management responsibility for the custody sergeants as they were line managed by their relevant patrol inspectors.
- 3.8 Police officers' postings in custody lasted for six months. Overall, there were at least 36 different custody sergeants who covered both custody suites from four patrol teams, with nine sergeants on each team. All custody sergeants had received nationally accredited custody training, which was delivered corporately, as had the DDOs. Police constable (PC) gaolers had not received custody-specific training before their deployment into the custody suites, apart from the initial training package on how to use the NSPIS custody system that was part of normal police training. Recent planned events that were resource intensive had seen the deployment of untrained staff into the custody suite to act as gaolers, although we were assured that lessons had been learned from this. For future operations, the custody manager would be contacted in advance to ensure that only suitably trained custody staff were deployed in custody suites. The MPS had recently brought in a custody sergeant refresher course that staff could ask to attend if they felt deskilled, but there was nothing locally to refresh police custody sergeants.
- 3.9 The police officers worked 12-hour shifts without time for a handover period factored into the shift scheme. The borough relied on the goodwill of police officers arriving early to complete a handover. The DDOs worked eight-hour shifts, so their handovers did not coincide with custody sergeant handovers. Turnover among DDO staff was described as high, with many leaving to become police officers. In terms of quality assurance of custody records and processes, the custody manager and BTR sergeants carried out regular dip sampling of custody records, including cross referencing these with the custody closed-circuit television tapes.
- 3.10 The appropriate adults scheme was not operating effectively (see section on individual rights).
- 3.11 There was no consistency between senior management and staff over whether complaints would be taken from a detainee in custody and the system in place did not ensure that all detainees were enabled to complain about their care and treatment (see section on individual rights). There was no identifiable feedback process from the Department for Professional Standards (DPS) to boroughs or custody managers about the number and type of complaints made and the acting borough commander had a more positive picture of the complaints situation than we believed to be the case. The combination of tactical and strategic weakness failed to identify opportunities for learning, solving underlying causes of complaints or identifying poor policing practices by individuals. It also had the potential to undermine confidence in how the police dealt with complainants, particularly for the not insignificant proportion who were not released from police custody.
- 3.12 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating adverse incidents. They also published a 'best of lessons learned' from the Independent Police Complaints Commission (IPCC), which the borough ensured was circulated and if necessary reinforced to the patrol teams personally by the custody manager when they were briefed at parade.

- 3.13 The acting borough commander said few issues arose regarding the CPS or London Direct (CPS), which he described as working well. An integrated crown prosecution team was based at Bethnal Green and he said the CPS was happy with the arrangements.
- 3.14 There was a MPA lead for the ICV scheme, which was viewed as an important independent oversight mechanism. ICVs visited the custody suites regularly and were clearly focused on standards and prisoner welfare. There were formal monthly ICV meetings where issues of concern were picked up by the custody manager and reports given back to the ICVs the following month. ICVs reported good relationships with custody staff in general, while the custody manager said relationships with the ICVs were good.
- 3.15 Some police officers seemed confused about when to take DNA samples, where to store them and what to do with them. A number of samples of DNA had not been submitted to the national DNA database and not all forensic exhibits were properly bagged, labelled and managed. In contrast, the DDOs were very clear about their role and responsibilities and effectively managed their DNA samples (see also section on individual rights).

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 staff and other employees who operate within the custody environment should not be deployed into custody suites until they have been given custody-specific training that includes training in how to use the NSPIS custody system.
- 3.18 Custody refresher training should be provided to all staff who work in the custody environment.
- 3.19 The Metropolitan Police Service should engage with relevant partners to ensure that there is an effective appropriate adult scheme in operation for both vulnerable adults and juveniles.
- 3.20 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.
- 3.21 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 Metropolitan Police Service should initiate a pan-borough search of all its fridges and freezers to ensure that all lawfully taken DNA samples are submitted to the national DNA database as soon as practicable. An audit trail of this procedure should be maintained and retained for future reference.

To the Metropolitan Police Authority

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

4. Treatment and conditions

Expected outcomes:

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

- 4.1 Staff were respectful towards detainees, but there was limited recognition of the different needs of women and juveniles, and no provision for detainees with disabilities. Interpreters were used to help detainees who did not speak English. Risk assessments were completed on arrival, but not always updated. Staff carried anti-ligature knives, but off-the-job refresher training was not available to all staff and detainees were not always told how or why to use cell bells. Force did not appear to be overused, but no central record was kept to allow regular monitoring. Bethnal Green was relatively clean, but Limehouse was not. Blankets and toilet paper and hygiene packs for women were not routinely provided. Detainees had to request access to a shower. They were given only paper towels and those whose clothing was removed were usually offered paper suits. Smokers were not offered nicotine replacements and the outside exercise areas were rarely used. A good range of meals was available. Visits were not facilitated.

Respect

- 4.2 Police vans brought detainees in and, if appropriate, SERCO took them to court. The court cut-off time (Thames Magistrates Court) was 1pm, but the custody sergeant at Limehouse said the volume of detainees needing to be dealt with sometimes meant this was brought forward to 11.30am. Staff at Bethnal Green said this rarely happened there.
- 4.3 Detainees were generally dealt with respectfully and during the inspection staff dealt with a number of difficult and challenging situations calmly and positively. Women being booked in were asked if they wanted to speak to a female officer and both suites had allocated detention rooms for women and juveniles, but there was little else to address the distinct needs of women in custody. Juveniles were checked more frequently and a triage system for juveniles coordinated by the youth offending team had been in place for about a month. This facilitated background checks on juveniles, providing a detailed input that aimed to divert them away from the criminal justice system. If detainees had dependency issues, the custody sergeant rang the number they requested and either passed the telephone to the detainee or spoke on their behalf. This took place at the booking in desk, which allowed little privacy.
- 4.4 Unlike Bethnal Green, Limehouse did not receive many immigration detainees. At Bethnal Green, staff recognised that immigration detainees tended to have extended lengths of stay and the professional telephone interpreting service was used regularly to provide rights and entitlements information. This service was used less often at Limehouse, but the rights and entitlements leaflets were regularly printed off in various languages. Prayer mats, beads and texts were available for religious needs. There was no cell adapted for use by detainees with mobility or other physical difficulties.

Safety

- 4.5 The custody sergeant completed a risk assessment on a detainee's arrival. If a detainee was unwilling or unable to cooperate with this, staff said they would rely on the observations of

custody officers and possibly increase the frequency of their checks or, if necessary, place the detainee on constant observations. Custody records showed detainees under the influence of drugs or alcohol were regularly roused. Risk assessments were sometimes, but not always, updated to reflect any new information. Some custody sergeants were concerned about giving verbal handovers on shift changes to inexperienced sergeants and believed this could pose a risk. All staff carried anti-ligature knives. A handover period was not built into the change of shifts to allow time for a full briefing. Custody sergeants overcame this by starting their shift early, but this was entirely dependent on goodwill.

- 4.6 PC gaolers said they were not given any training in dealing with people with mental health problems. They were informed in advance if a detainee was being violent and arresting officers usually entered before the detainee so that staff could ensure the cell was ready and the custody area clear.

Use of force

- 4.7 No Tasers or incapacitant sprays were carried or used by custody staff and staff at Limehouse said they would call the Territorial Support Group if either was required. Staff said they would use handcuffs on particularly violent detainees, but would first try to deescalate the situation. They also used cell relocation if a detainee was refractory or damaging a cell.
- 4.8 Uses of force were noted on custody records and in the evidence log, but there was no central recording or separate account for monitoring purposes. PC gaolers made a note in their pocket book. Custody records did not show force was inappropriately used. Custody staff said they would not automatically call an FME after all uses of force, but only in more serious cases.

Physical conditions

- 4.9 Cells at Limehouse were dirty and contained a lot of graffiti. They were cleaned twice a day, but not routinely between uses and we saw detainees placed in cells that had not been cleaned after the previous occupant had left. One cell contained used toilet paper beside the toilet. The flooring was particularly poor and difficult to keep clean. Cleaning staff could be called out if a cell being vacated was in a particularly bad state.
- 4.10 In contrast, Bethnal Green was relatively clean and well presented with little graffiti, although the men's showers were dirty. Whiteboards outside the cells displayed the name and offence of the detainee. There was a staple in one of the toilets and the toilet seat base in another had come loose, providing the opportunity to self-harm or conceal small items. One cell (M12) was particularly noisy due to the air conditioning system. The seating in the interview room was not bolted down and the furniture was in poor condition.
- 4.11 Both suites enforced a no smoking policy, but smokers were not offered nicotine replacement therapy.
- 4.12 The custody sergeant said fire drills took place every few months, but there was no record of the frequency of drills. Plastic cuffs available at the booking-in desk could be used when escorting detainees to the exercise yard in the event of a fire.
- 4.13 The use of cell call bells was not routinely explained to detainees, but we saw staff responding to them promptly.

Personal comfort and hygiene

- 4.14 A mattress and pillow were routinely provided, but blankets had to be requested. Dirty blankets were stored on an open rack in the detention area. The pillows at Limehouse were shabby and cracked and, like the mattresses, not routinely cleaned after use.
- 4.15 Toilet paper had to be requested, as did access to showers. Custody records showed that few detainees had a shower. Only paper towels were available. Sanitary products were not routinely offered to female detainees, but were available on request. The only shower at Limehouse was in the men's area and had a short stable door that meant it lacked privacy. This made it particularly unsuitable for women to use.
- 4.16 Paper suits were usually offered instead of track suits to detainees whose clothing had been removed. Staff said there were problems with supplies of track suits and plimsolls, which were therefore kept in reserve because the courts did not receive detainees in paper suits. There were no clean supplies of underwear.

Catering

- 4.17 Food at Limehouse was provided by the station canteen, which was open 24 hours a day, and drinks were routinely offered. Bethnal Green had the same arrangements during the working day and used microwave meals at other times. These were of a better quality than seen in some other places and included a good range of options included halal, vegetarian and vegan food.

Activities

- 4.18 Outside areas where detainees could get some fresh air were rarely, if ever, used. Detainees at Limehouse were not offered something to read, but those at Bethnal Green were and staff there also provided newspapers. Visits were not facilitated at either suite.

Recommendations

- 4.19 Telephone calls made on behalf of detainees with dependency issues should be made in private.
- 4.20 Adapted cells should be available for use by detainees with a disability.
- 4.21 Changes in information about a detainee's condition should always be reflected in a revised risk assessment, which should be noted on the custody record.
- 4.22 There should be a formal system in place to ensure that full information on detainees is shared with the custody sergeants during changes in shift.
- 4.23 PC gaolers should be provided with training on dealing with people with mental health problems.
- 4.24 Uses of force should be monitored centrally to identify any issues or trends.
- 4.25 Following the use of force, detainees should be seen by a healthcare professional as soon as practicable.

- 4.26 Cells should be cleaned between uses and kept clean, free of graffiti and functional for use.
- 4.27 The flooring at Limehouse should be replaced as soon as practicable.
- 4.28 Mattresses and pillows should be cleaned between uses and those in a poor state of repair should be replaced.
- 4.29 On an individually assessed basis, nicotine replacement should be available to smokers.
- 4.30 Furniture in a poor state of repair in the interview rooms should be replaced.
- 4.31 Records of fire drills should be maintained.
- 4.32 Basic necessities, such as blankets, showers for detainees who need one or those held over 24 hours, toilet paper and hygiene packs, should be offered proactively.
- 4.33 Detainees should be offered a shower, particularly if they are held for 24 hours.
- 4.34 Female detainees at Limehouse should be able to shower in an appropriate environment that allows sufficient privacy.
- 4.35 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees.
- 4.36 The use of cell bells should routinely be explained to detainees.
- 4.37 Dirty blankets should not be stored in an open area in the detention area.
- 4.38 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air.
- 4.39 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.
- 4.40 Visits should be allowed for those detained more than 24 hours and for young people.

Housekeeping point

- 4.41 The noisy air conditioning in the cell at Bethnal Green should be examined with a view to making it more comfortable for detainees.

5. Individual rights

Expected outcomes:

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

5.1 Detention reviews were completed on time, but not always by the PACE inspector. Custody sergeants were respectful towards detainees. NSPIS was often poorly completed and quality monitoring was not widely disseminated. Telephone interpretation was generally well used, but not for detention reviews. Immigration detainees were regularly held, sometimes for lengthy periods. There were no set procedures to help those with vulnerable dependants and a new pre-release risk assessment process was poorly implemented. The appropriate adult scheme was ineffective. Solicitors had good access to the custody suites, but immigration detainees had little access to specialist legal advice. A number of samples of DNA had not been submitted to the national DNA database and management of forensic samples was poor at Bethnal Green. The complaints system was unclear and potentially serious complaints were ignored. There was no system to manage racist incidents. Detainees were routinely strip searched.

Rights relating to detention

- 5.2 Detention reviews were completed at appropriate intervals. There was a designated PACE inspector, whose duties included completion of most reviews at Bethnal Green and Limehouse. He sometimes spoke to the detainee by telephone if he was not at the station when a review was due, but regularly did not speak to detainees personally and relied instead on custody staff asking questions and relaying information to him.
- 5.3 Custody sergeants were clear and respectful in their explanations to detainees. The atmosphere in both suites was calm and well ordered, mainly due to the positive tone set by custody sergeants. NSPIS was often poorly completed, with confusing entries, usually because standard statements had not been amended. One standard entry stated that a detainee had been 'informed of his right to legal advice' even though he was clearly asleep at the time. Other custody records did not state when custody had ended or when mechanical restraints had been removed.
- 5.4 The custody inspector, assisted by sergeants who did not work in the custody suites, undertook quality monitoring of 10% of custody records. This had produced useful findings and some individuals were informed of their practices, good or bad, and required to improve their performance where necessary. However, key findings were not disseminated to all custody staff for learning purposes.
- 5.5 During the previous three months, the custody suites had been used 25 times as a place of safety for children and young people under section 46 of the Children Act (1989). Staff said the young people were never brought into the custody suites while waiting for social workers and instead waited elsewhere in the station.
- 5.6 Immigration detainees were rarely held at Limehouse, but Bethnal Green received about four or five a week, some of whom were held for a few days. Staff described the responsiveness of UK Border Agency (UKBA) offices as variable and some records included unexplained delays following earlier assurances that detainees would be collected. However, custody sergeants

agreed that communication with UKBA had improved over the previous two years and the length of detention had reduced. Records showed that custody staff were persistent in contacting UKBA offices to progress matters.

- 5.7 Reasonable efforts were made to communicate with foreign nationals who did not speak English. The telephone interpreting service was well used, usually in Bethnal Green and mainly for booking in detainees. However, there was little evidence that interpreters were used for detention reviews and some other occasions when it had clearly been required. One custody record stated repeatedly that a detainee was not being informed of his rights due to language difficulties, but with no attempt to use an interpreter. A separate brief form on NSPIS aimed to ensure that foreign nationals were offered embassy contact, but some detainees did not understand this offer because of language problems and lack of interpretation. The only example in our sample of an immigration detainee asking for embassy contact showed that staff had telephoned several times but had not got through.
- 5.8 The rights and entitlements leaflet was given out to all detainees and was available in 46 languages. In Limehouse, 'remember your rights' posters were displayed in English and Bengali, one of the more predominant languages in the local area. These posters were not displayed at Bethnal Green, although a notice advertising the right to legal advice had been translated into 11 languages.
- 5.9 A new question on NSPIS asked whether female detainees wanted to see a female officer. There was no other recognition of the distinct needs of women. Sanitary products were not offered automatically and the shower at Limehouse was unsuitable for women to use (see section on treatment and conditions).
- 5.10 There were no set operating procedures for assisting those with vulnerable dependants. Staff used common sense and said they had in the past, for example, allowed telephone calls to arrange childcare. However, the approach was inconsistent between staff, some of whom were unsure what to do when faced with this or other more serious situations.
- 5.11 Two basic questions about pre-release risk assessment had been added to NSPIS and a leaflet detailing various community support organisations was available. However, staff were not confident about completing the assessment and the relevant section was rarely filled in. Even when it was, it did not always address apparent risks. One female detainee had been released to go home at about 9.30pm and the record had been marked 'no risk apparent' even though she had a record of self-harm, was taking medication, had mental health problems and had been intoxicated on arrival.

Rights relating to PACE

- 5.12 The appropriate adult scheme did not operate effectively, either for vulnerable adults or juveniles. A previous separate scheme had fallen into disuse, apparently because of reluctance to attend, and staff said they would contact social services if a family member was unable to fulfil the role. In relation to vulnerable adults, a mental health appropriate adult scheme was under discussion with a local charity, but had not yet been implemented.
- 5.13 Staff, particularly at Limehouse, said there were considerable delays in the arrival of appropriate adults, who would not normally attend until a solicitor arrived. This left vulnerable and juvenile detainees in custody for some time without any support, and could extend the period they spent in custody. One young person booked in at 10am was not seen by the appropriate adult until the afternoon. Limehouse staff may not have been particularly

expeditious in calling in appropriate adults in any case: a 15 year old brought in at about 1pm did not see his father until about 10pm, even though the father had left his telephone number and asked to be called when needed.

- 5.14 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 unless otherwise deemed vulnerable. We saw a 17 year old young woman, who had been detained in hospital under Section 136 of the Mental Health Act, but transferred to the police station because she was drunk and aggressive. She claimed to have been sexually abused, but it was decided there was no information on which to prosecute. She was not provided with an appropriate adult and in spite of representations from her mother about both her mental health and the sexual abuse allegations, her circumstances were not initially reported to the local children's safeguarding services, until inspectors followed this up.
- 5.15 Custody staff reported no difficulties in obtaining duty solicitors. Solicitors themselves were mostly positive about levels of access and the helpfulness of staff, although some complained that custody staff did not inform them of changes relevant to detainees, such as absences for hospital visits. Immigration detainees were often unrepresented due to the lack of legal aid for immigration work. There was no written information and little awareness among staff of other agencies, such as Refugee and Migrant Justice or the Immigration Advisory Service.
- 5.16 Custody records were generally provided on request to detainees or solicitors. However, this did not always happen consistently as some custody staff were unsure whether they were allowed to provide records containing medical information, even though any highly confidential information would not have been on NSPIS.
- 5.17 Detainees could obtain PACE Code C on request, but only two copies were available at Limehouse, one of which was out of date. Staff at Bethnal Green said they had three copies, but only one could be found.
- 5.18 Management of forensic samples varied. At Limehouse, the fridge and freezer were packed full, but cleared of samples more than two months old by a designated detention officer (DDO). A log book usually indicated what had been done with samples, but was not always completed. At Bethnal Green, the freezer was so full of DNA exhibits and forensic samples that the door had to be taped shut. The management of samples was poor and some were well over a year old. DDOs said this freezer had contained numerous other DNA samples until two months previously, when a lot had been destroyed in a clearout.
- 5.19 At Bethnal Green, we found 41 PACE DNA or evidential DNA samples and 11 volunteer DNA samples that had not been submitted to the national DNA database or processed. It was not possible to determine why, but a small number of samples appeared to have been rejected due to lack of an authorisation code or proper documentation. The DNA samples included offences of robbery, burglary and other violent crimes as well as DNA rejected in November and December 2008. It was not known whether these rejections were followed up by police officers, with suspects asked to provide another sample. In terms of forensic samples, we found a urine sample from a drink drive case dated August 2008 that had not been submitted for analysis. An apparently used nail clipper had not been sealed in an evidential exhibit bag and contained no identifying paperwork or officer in case. There were exhibits that had been submitted for DNA profiling in October 2008 and rejected due to lack of continuity of evidence. We asked the local detective chief inspector to review our findings to see if there was any viable explanation, but he could not provide one.

- 5.20 A freezer at Limehouse police station contained eight PACE DNA samples, five of which were taken on 25 and 26 May 2009 and had not been sent to the national DNA database. There were 27 volunteer/elimination samples, many of which had been taken from detainees suspected of involvement in violent offences. We checked the five detainees who had had DNA PACE samples taken on 25 and 26 May 2009 and two who had provided volunteer samples on the Police National Computer (PNC). All seven individuals were already on the PNC as 'DNA confirmed' or 'DNA profiled', with dates in 2006, 2007 and 2008. We found 87 PACE, evidential or volunteer samples of DNA that had not been submitted for analysis or comparison, or destroyed. DDOs, detective constable, sergeant, inspector and chief inspector ranks we spoke to could not provide a rational explanation for what we found. In general, the fridges and freezers were not suitable for the task they were used for.
- 5.21 Detainees were not interviewed while under the influence of substances. Custody records showed that custody staff often carried out assessments to establish whether detainees were fit for interview. Other records showed the timing of interviews was carefully planned to allow detainees to rest and eat and to avoid excessive or evening interviewing.
- 5.22 Custody sergeants said the service from Serco, the escort provider for discharges to court, was generally efficient. If Serco was unable to collect, detainees were taken by police staff as the court was nearby. Detainees were required to be booked into the local court by 1pm, which meant some could be kept in custody longer than necessary. Courts also sometimes refused to take detainees because of a lack of space in court cells. Neither suite had video link facilities.

Rights relating to treatment

- 5.23 There were differences in how senior management and staff thought the complaints system operated. The SMT and custody manager said complaints were not taken while detainees were in custody unless they were of a serious nature and evidence needed to be secured immediately. A PACE inspector said a complaint was taken from a detainee in custody only if they alleged assault and photographs needed to be taken or an FME called. However, staff working day to day in custody said detainees were told to make their complaint at the front of the police station on release to avoid being held in custody during any investigation. This had the effect of discouraging complaints, undermined the principle of speedy investigation into allegations and meant they were usually not dealt with during detention even if there was time.
- 5.24 Detainees were not given any information about making complaints and were unsure about how they could do so formally. In our survey of prisoners who had previously been held at Tower Hamlets, only 13% said they had been told how to make a complaint. We viewed a DVD of the booking in process of a detainee who had complained to us that he had been assaulted. The tape showed that he had large areas of bruising and cuts, which were noted on his custody record and said to be the result of baton strikes. During the booking in process, the detainee told the custody sergeant clearly and calmly that he had been assaulted by the arresting officer and that this was the cause of his injuries. He asked when his complaint would be heard, but was told he could complain later. No complaint was taken and neither his request to complain nor the assault allegation was recorded on his custody record. Managers did not monitor the number and nature of complaints with a racial element so any trends were not acted on. Custody records indicated that detainees were routinely strip searched, often without clear reason.

Recommendations

- 5.25 Custody records should provide an accurate and clear picture of a detainee's experience of custody.
- 5.26 The results of internal quality control audits should be summarised, anonymised and disseminated to all custody staff, with areas for improvement clearly highlighted.
- 5.27 The telephone interpretation service should be used whenever necessary, including for detention reviews and administering rights.
- 5.28 More posters should be displayed where detainees can see them and in a range of common local languages.
- 5.29 The UK Border Agency should ensure that immigration detainees are held for the shortest possible time.
- 5.30 At the point of detention, immigration detainees should be provided with information about relevant advice and support agencies.
- 5.31 Staff should receive training in how to meet the specific needs of detained women.
- 5.32 Standard procedures should be established for assisting those with vulnerable dependants.
- 5.33 More and up to date copies of PACE Code C should be held in the custody suites and detainees should be made aware that they can request them.
- 5.34 Custody records should be provided on request to detainees or solicitors.
- 5.35 Appropriate adults should be available to support vulnerable adults and children throughout the custody process, and should be available without undue delay.
- 5.36 Detainees aged 17 years should be provided with an appropriate adult, and staff should be alert to any child protection issues they present.
- 5.37 The court service and the borough commander should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links.
- 5.38 The pre-release risk management policy should be implemented consistently, with actions taken recorded on NSPIS. Custody staff should receive training in this process.
- 5.39 Consideration should be given by the Metropolitan Police Service to providing boroughs centrally with fridges and freezers that are of an industrial standard.
- 5.40 All PACE DNA samples should be submitted to the national DNA database or destroyed as soon as practicable. This should be closely monitored at a senior management team level.
- 5.41 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.

- 5.42 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.
- 5.43 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on.
- 5.44 Strip searching should take place only on the basis of risk assessment.

6. Healthcare

Expected outcomes:

Detainees have access to competent healthcare professionals who meet their physical health, mental health and substance use needs in a timely way.

6.1 Health services were provided by forensic medical examiners under a new contract with the Police Authority. Governance arrangements for the contract were not clear and there was an absence of robust policies and protocols reflecting national practice. The service was satisfactory, but there were some long waits and short consultations. Record-keeping was reasonable but inconsistent. Medication was grossly over-stocked despite new guidelines. There was a lack of awareness among staff about mental health services available and response times varied widely. Access to drug and alcohol support was inconsistent.

Clinical governance

- 6.2 Clinical governance arrangements for the forensic medical examiners (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 specify response times, appraisals or professional development. There was no monitoring at a local level of the contracts, although we understood that this was carried out across the Metropolitan Force.
- 6.3 The Tower Hamlets BCU did not check to ensure that annual appraisals were completed, supervision provided and accessed or continuous professional development undertaken in line with the requirements of their professional bodies. However, we were told that a medical director was soon to be appointed and would take on this role among other duties. Apart from a short induction, no mandatory training had been provided by the MPS. No checks were made of whether or how FMEs updated their clinical skills.
- 6.4 There appeared to be an absence of robust governance arrangements or healthcare policies and protocols that reflected current national guidance and healthcare legislation to provide a framework for a quality service. There was no systematic approach to monitoring or audit against standards, policy or practice and a lack of established management structures and mechanisms for addressing such findings in good time. This was apparent both internally and with external partner agencies.
- 6.5 There was no evidence that a training needs analysis had been undertaken among healthcare professionals. FMEs we spoke to were also GPs in the community so were able to maintain clinical competence and professional development through other channels. However, some were locum doctors and custody staff had no way of knowing what qualifications or experience the doctor had when he or she arrived at the suite.
- 6.6 There was only one female FME on the rota and it was not clear what would happen if a female detainee requested a female doctor. A PC gaoler routinely accompanied male and female detainees when they saw the FME. Staff said the decision for a chaperone was made on the basis of risk, but there was no evidence of a risk assessment being made at the time or immediately before any consultation.

- 6.7 Telephone interpreters were used if a detainee did not speak English, but there was no facility for this service in the FME room. One such consultation during the inspection therefore took place at the custody desk in full hearing of other detainees and staff.
- 6.8 Neither of the FME rooms was clinically clean, although the one at Bethnal Green was not as dirty as that at Limehouse. We did not consider that it was possible to ensure that either room was forensically clean. The same clinical waste was on the floor in the Limehouse room for two consecutive days and there was thick dust on high units. A report from the Emerald Custody Directorate had reported that the FME room at Limehouse was dirty. The examination light in the room at Bethnal Green was broken and the freezer was held closed by tape (see section on individual rights). There was no antibacterial hand cleanser in either FME room. General and clinical waste was disposed of in the yellow clinical waste bags and there were no general waste bins. Sharps and general waste were disposed of in the sharps boxes, none of which were dated and signed when first used. There were a number of resheathed needles in the sharps bins, presenting a risk of needle stick injury and contrary to national guidance. Staff said sharps bins were emptied only when full. Clinical waste was collected regularly by an external contractor and additional collections could be made on request. The service level agreement for clinical waste was not held at the stations for viewing.
- 6.9 There was no signage on medical examination room doors in either suite and these were left unlocked when not in use on several occasions during the inspection. The room at Limehouse was very small so all consultations had to take place with the door open. The door to the FME room opened out to one side of the busy main custody reception area and all conversation in both areas could clearly be heard in the other.
- 6.10 A range of medical equipment, such as stethoscopes and blood pressure monitors, was locked in the cupboards at Bethnal Green, as well as dressings and other equipment, some of which was out of date. Some forensic sampling kits were also out of date and others were opened.
- 6.11 Medications management was poor. We found gross overstocking of medications, particularly at Bethnal Green. There were 47 GTN (angina) sprays against a stock level (determined by Forensic Health Services) of three and three of these were out of date. There were over 60 boxes of indigestion tablets in two separate cupboards, some of which were out of date, against a stock level of one pack. FMEs said they carried their own supplies of medications with them and dispensed these to patients as they could not be sure that the medications required would be available in the custody suites. It was not known whether similar individual arrangements were made by agency medical practitioners. There were no up-to-date drug reference books available.
- 6.12 Records of medications administered from stock were not completed correctly or presented in an auditable form. Arrangements for the delivery of medications were also poor. A large box of medications was delivered to Limehouse on the first day of the inspection. No one knew what to do with it and it was eventually put in the safe. No one had told the custody support manager of its existence by the following day and she described other occasions when medications had been delivered to the front desk or left on her desk for days when she was on leave.
- 6.13 Boxes for the destruction of medications were available in each FME room, but were not dated and one was not sealed. Some custody staff were unaware of their existence.
- 6.14 The defibrillator at Bethnal Green was checked daily, but there was no evidence of regular checks at Limehouse. There were redivacs (suction equipment) and ligature shears available for immediate use at Bethnal Green, but the suction equipment at Limehouse needed to be

assembled. First aid kits were also available. They were sealed and checked, although a bottle of eye wash in one kit had expired over five years previously. Some, but not all, staff had in-date first aid and resuscitation training.

Patient care

- 6.15 Detainees were asked on arrival if they wished to see a doctor. The FMEs also covered part of Hackney BCU and FMEs and custody staff said agency medical staff regularly covered up to three boroughs on one shift, which adversely affected response times. Locally, there were no formal mechanisms to monitor response rates or the overall quality of the service. Staff described waits of over five hours. When there were long delays for the FME to respond, a further call was made to ascertain time of arrival and these were also recorded.
- 6.16 Our analysis of custody records showed that 13 (43%) of detainees had either requested an FME or the police had requested one on their behalf. Two had left the station without the doctor arriving. The shortest waiting time was one minute, because the doctor was on site, while the longest was four hours. The average was 1.5 hours. Doctors and custody staff described problems in getting a doctor to attend close to the beginning or end of an FME shift. One custody record showed that a doctor called for a detainee who was apparently fitting had said he could not attend and that the call would have to be passed to the next doctor at the beginning of his shift. We saw one FME who did not communicate with the custody sergeant when he arrived or when he left, while another made a point of ensuring that the sergeant was satisfied with his findings and treatment before leaving.
- 6.17 Consultations were often brief. One doctor saw six patients in 44 minutes. The longest time taken to undertake a review of a patient already seen was four minutes and the shortest was two minutes. Of the two new patients, one consultation took two minutes and the other six.
- 6.18 Custody staff provided some good care of detainees' health needs.
- 6.19 Apart from inhalers, detainees were not allowed any medication, even what they had brought in with them, before seeing the FME. Given some of the delays in an FME attending, this was potentially detrimental to patient care. Medications required by detainees after consultation with the FME were dispensed by the FME and either given immediately or clipped to the custody record to be administered later. No training on the administration of medicines had been provided to the custody staff. There were arrangements for the police to obtain a prescription from a pharmacy for any medication not held in stock or carried by the FME.
- 6.20 FMEs said they would not routinely provide symptomatic relief to detainees experiencing withdrawal symptoms. One detainee known to be a chronic alcoholic had received no medications despite being in custody for over six hours. In our survey, only eight of 23 detainees who stated they had drug or alcohol problems had been given 'relief medication of their immediate symptoms' while in custody.
- 6.21 Most FMEs used NSPIS to record clinical information relevant to the care of the detainee. However, locum doctors did not have access to it so custody staff had to transcribe their notes onto the system. Some doctors also used the book 83 and some also kept their own notes. There was no consistency. The recording of clinical findings in NSPIS records varied and it was difficult, and sometimes impossible, to determine when medications had been given. The documentation in the book 83s was poor. The FME contract made clear 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 GMC. FMEs were responsible for their retention and secure storage.

- 6.22 FMEs we spoke to had different opinions on whether they would provide a copy of the clinical notes to a detainee, with most stating they would do so only to a solicitor following a written request. However, custody staff had given one legal representative at Bethnal Green a copy of his client's NSPIS printout that included the clinical consultation.
- 6.23 Staff said there were no information sharing protocols with all appropriate partner agencies to ensure the efficient sharing of relevant health and social care information.
- 6.24 None of the staff interviewed had undertaken specific Mental Health Act and Mental Capacity Act training in line with recent changes in legislation. Safeguarding children update training had not been provided to all, apparently due to a general lack of available training opportunities and the lack of staff to cover for those being trained. It was not unusual for custody staff to have to cancel attendance at training at short notice.

Substance use

- 6.25 Adult detainees who had allegedly committed 'trigger offences' and all those who tested positive to Class A drugs were referred to the arrest referral worker. Workers were on site at Bethnal Green between 7am and 10pm daily. They were employed by Tower Hamlets Council as part of the drug and alcohol team (DAT). Workers saw those with drug and alcohol issues at Bethnal Green and made regular contact with Limehouse and could visit if required. Everyone referred underwent an initial assessment, as did those who self-referred either on arrival at the station or during one of the workers' visits to individual cells at Bethnal Green. Detainees who lived within the borough were given an appointment for the DAT team within two to three days of the initial assessment. Those living outside the borough were referred to the relevant area team. Detainees with alcohol problems were spoken to and referred to the Drugs and Alcohol Service for London.
- 6.26 Local DAT figures indicated that the team had assessed 433 detainees in the first six months of 2009, of whom 347 were assessed at a police custody suite. Twenty-eight (6.5%) were voluntary assessments. Only 17 (4.9%) of the assessments in custody suites were undertaken at Limehouse. Our analysis of custody records (see appendix II) revealed that none of the detainees at Limehouse had been offered the services of a drugs worker, while three held at Bethnal Green had been offered or had had contact with a drugs worker. None of the staff we interviewed could recall a drugs worker attending Limehouse to assess a detainee. In our survey, 60% said they had drug or alcohol problems and 37% had been offered the chance to see a drug or alcohol support worker.
- 6.27 Workers did not supply clean needles and syringes to detainees on release, but would provide details of where these could be obtained if asked. The DAT workers spoke to juveniles, but then referred them to the YOT worker based at Bethnal Green police station.

Mental health

- 6.28 There was no mental health worker based at either station. Detainees requesting mental health services or displaying florid mental health distress were referred to the FME for health assessment. A referral was then made to the community mental health team as deemed appropriate by the FME. This meant detainees had to wait significant periods of times to see a mental health professional.

- 6.29 Interviews with a range of custody staff and representatives from the community mental health team revealed differing perceptions of the responsiveness and effectiveness of the mental health services. Custody staff reported wide variations in response times and said they believed detainees were given a lower priority for assessment as they were seen to be already in a place of safety. However, the mental health team reported a responsive, fit for purpose service and good working relationships with police custody staff.
- 6.30 The community mental health services were arranged around a four team configuration, with each team covering a different area of the borough, so different teams covered each of the two police stations and the local accident and emergency department. The community teams offered 24-hour services with competing priorities to manage as appropriate. It was reported that mental health teams worked primarily to keep patients appropriately and safely in the community rather than admitting to in-patient wards. Following a mental health assessment, a treatment plan would be agreed. There were limited beds available in the area, which sometimes led to lengthy post assessment waits while an out of area bed was identified.
- 6.31 The number of referrals for a mental health assessment was low, possibly due to a lack of awareness of mental health issues among police and FMEs. Mental health staff said those who were referred were appropriate. There was limited optimal space at either station, but particularly Limehouse, for mental health assessments to be undertaken, and patient comfort, privacy and confidentiality were issues.
- 6.32 A similar service was offered for juveniles using the same teams. Each team contained mental health professionals trained to assess paediatric patients. Fourteen such mental health assessments had been undertaken in the previous year.
- 6.33 Custody suites were not normally used for people detained under the Mental Health Act (1983) Section 136. Such potential cases were taken to a designated mental health suite at the local accident and emergency department. Figures given by the local mental health trust stated that 37 people been taken to the suite in 2008/09, of whom 30 had subsequently been detained under Section 136 of the Act. The same report identified that in 11 instances, assistance had been provided at a police station, but the individual stations were not identified. On further investigation, these figures were found to differ from those held by the Trust's MHA office, which reported 61 people detained under Section 136 in 2008/09.
- 6.34 There was limited specific monitoring and audit of the standards and quality of the mental health service, although there was an established named police liaison officer with a responsibility for liaison with the local mental health services. This was described by staff we spoke to as a positive arrangement and provided a conduit for issues to be identified with actions planned and taken. However, meetings between the liaison officer and the mental health team were informal and not minuted.

Recommendations

- 6.35 Custody staff should have mechanisms for checking locum forensic medical examiners' identity and qualifications at any time.
- 6.36 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.

- 6.37 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development.
- 6.38 Female detainees should be able to see a female doctor on request.
- 6.39 Risk assessments to determine the need for a chaperone during a clinical consultation should be carried out and documented contemporaneously.
- 6.40 There should be arrangements to support detainees who cannot speak English so that consultations with forensic medical examiners can be conducted in private.
- 6.41 There should be clear infection control procedures, including cleaning schedules that are adhered to and monitored.
- 6.42 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.
- 6.43 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.
- 6.44 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance.
- 6.45 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.
- 6.46 Detainees should be able to obtain the results of any clinical examinations.
- 6.47 Detainees at Limehouse should have the same level of service from a drug action team worker as those at Bethnal Green.
- 6.48 Injecting drug users being released into the community should be offered clean needles by drugs workers.
- 6.49 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.
- 6.50 There should be robust monitoring arrangements and audit of the standards and quality of the mental health service delivered to detainees.
- 6.51 Custody sergeants should attend mental health awareness training.

Housekeeping points

- 6.52 The forensic medical examiner rooms should be locked when not in use.

- 6.53 Healthcare professionals should have access to up-to-date drug reference books.
- 6.54 Forensic sampling kits should be subject to stock rotation.
- 6.55 Forensic sampling kits should be discarded once opened and any part of the kit is used.
- 6.56 The examination light at Bethnal Green should be replaced.

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 staff and other employees who operate within the custody environment should not be deployed into custody suites until they have been given custody-specific training that includes training in how to use the NSPIS custody system. (3.17)
- 7.3 Custody refresher training should be provided to all staff who work in the custody environment. (3.18)
- 7.4 The Metropolitan Police Service should engage with relevant partners to ensure that there is an effective appropriate adult scheme in operation for both vulnerable adults and juveniles. (3.19)
- 7.5 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)
- 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 Metropolitan Police Service should initiate a pan-borough search of all its fridges and freezers to ensure that all lawfully taken DNA samples are submitted to the national DNA database as soon as practicable. An audit trail of this procedure should be maintained and retained for future reference. (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 Telephone calls made on behalf of detainees with dependency issues should be made in private. (4.19)
- 7.10 Adapted cells should be available for use by detainees with a disability. (4.20)

- 7.11 Changes in information about a detainee's condition should always be reflected in a revised risk assessment, which should be noted on the custody record. (4.21)
- 7.12 There should be a formal system in place to ensure that full information on detainees is shared with the custody sergeants during changes in shift. (4.22)
- 7.13 PC gaoles should be provided with training on dealing with people with mental health problems. (4.23)
- 7.14 Uses of force should be monitored centrally to identify any issues or trends. (4.24)
- 7.15 Following the use of force, detainees should be seen by a healthcare professional as soon as practicable. (4.25)
- 7.16 Cells should be cleaned between uses and kept clean, free of graffiti and functional for use. (4.26)
- 7.17 The flooring at Limehouse should be replaced as soon as practicable. (4.27)
- 7.18 Mattresses and pillows should be cleaned between uses and those in a poor state of repair should be replaced. (4.28)
- 7.19 On an individually assessed basis, nicotine replacement should be available to smokers. (4.29)
- 7.20 Furniture in a poor state of repair in the interview rooms should be replaced. (4.30)
- 7.21 Records of fire drills should be maintained. (4.31)
- 7.22 Basic necessities, such as blankets, showers for detainees who need one or those held over 24 hours, toilet paper and hygiene packs, should be offered proactively. (4.32)
- 7.23 Detainees should be offered a shower, particularly if they are held for 24 hours. (4.33)
- 7.24 Female detainees at Limehouse should be able to shower in an appropriate environment that allows sufficient privacy. (4.34)
- 7.25 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees. (4.35)
- 7.26 The use of cell bells should routinely be explained to detainees. (4.36)
- 7.27 Dirty blankets should not be stored in an open area in the detention area. (4.37)
- 7.28 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air. (4.38)
- 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. (4.39)
- 7.30 Visits should be allowed for those detained more than 24 hours and for young people. (4.40)

Individual rights

- 7.31 Custody records should provide an accurate and clear picture of a detainee's experience of custody. (5.25)
- 7.32 The results of internal quality control audits should be summarised, anonymised and disseminated to all custody staff, with areas for improvement clearly highlighted. (5.26)
- 7.33 The telephone interpretation service should be used whenever necessary, including for detention reviews and administering rights. (5.27)
- 7.34 More posters should be displayed where detainees can see them and in a range of common local languages. (5.28)
- 7.35 At the point of detention, immigration detainees should be provided with information about relevant advice and support agencies. (5.30)
- 7.36 Staff should receive training in how to meet the specific needs of detained women. (5.31)
- 7.37 Standard procedures should be established for assisting those with vulnerable dependants. (5.32)
- 7.38 More and up to date copies of PACE Code C should be held in the custody suites and detainees should be made aware that they can request them. (5.33)
- 7.39 Custody records should be provided on request to detainees or solicitors. (5.34)
- 7.40 Appropriate adults should be available to support vulnerable adults and children throughout the custody process, and should be available without undue delay. (5.35)
- 7.41 Detainees aged 17 years should be provided with an appropriate adult, and staff should be alert to any child protection issues they present. (5.36)
- 7.42 The court service and the borough commander should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links. (5.37)
- 7.43 The pre-release risk management policy should be implemented consistently, with actions taken recorded on NSPIS. Custody staff should receive training in this process. (5.38)
- 7.44 Consideration should be given by the Metropolitan Police Service to providing boroughs centrally with fridges and freezers that are of an industrial standard. (5.39)
- 7.45 All PACE DNA samples should be submitted to the national DNA database or destroyed as soon as practicable. This should be closely monitored at a senior management team level. (5.40)
- 7.46 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. (5.41)

- 7.47 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. (5.42)
- 7.48 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.43)
- 7.49 Strip searching should take place only on the basis of risk assessment. (5.44)

To the UK Border Agency

- 7.50 The UK Border Agency should ensure that immigration detainees are held for the shortest possible time. (5.29)

Healthcare

- 7.51 Custody staff should have mechanisms for checking locum forensic medical examiners' identity and qualifications at any time. (6.35)
- 7.52 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. (6.36)
- 7.53 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development. (6.37)
- 7.54 Female detainees should be able to see a female doctor on request. (6.38)
- 7.55 Risk assessments to determine the need for a chaperone during a clinical consultation should be carried out and documented contemporaneously. (6.39)
- 7.56 There should be arrangements to support detainees who cannot speak English so that consultations with forensic medical examiners can be conducted in private. (6.40)
- 7.57 There should be clear infection control procedures, including cleaning schedules that are adhered to and monitored. (6.41)
- 7.58 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. (6.42)
- 7.59 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. (6.43)
- 7.60 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance. (6.44)
- 7.61 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. (6.45)
- 7.62 Detainees should be able to obtain the results of any clinical examinations. (6.46)

- 7.63 Detainees at Limehouse should have the same level of service from a drug action team worker as those at Bethnal Green. (6.47)
- 7.64 Injecting drug users being released into the community should be offered clean needles by drugs workers. (6.48)
- 7.65 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. (6.49)
- 7.66 There should be robust monitoring arrangements and audit of the standards and quality of the mental health service delivered to detainees. (6.50)
- 7.67 Custody sergeants should attend mental health awareness training. (6.51)

Housekeeping points

Treatment and conditions

- 7.68 The noisy air conditioning in the cell at Bethnal Green should be examined with a view to making it more comfortable for detainees. (4.41)

Healthcare

- 7.69 The forensic medical examiner rooms should be locked when not in use. (6.52)
- 7.70 Healthcare professionals should have access to up-to-date drug reference books. (6.53)
- 7.71 Forensic sampling kits should be subject to stock rotation. (6.54)
- 7.72 Forensic sampling kits should be discarded once opened and any part of the kit is used. (6.55)
- 7.73 The examination light at Bethnal Green should be replaced. (6.56)

Appendix I : Inspection team

Anne Owers	-	HM Chief Inspector of Prisons
Sean Sullivan	-	HMIP team leader
Hindpal Singh Bhui	-	HMIP team leader
Anita Saigal	-	HMIP inspector
Paddy Craig	-	HMIC inspector
Fiona Sheerlaw	-	HMIC inspector
Bridget McEvilly	-	HMIP healthcare inspector
Elizabeth Tysoe	-	HMIP healthcare inspector
Marilyn Hansford	-	CQC inspector
Catherine Nichols	-	HMIP researcher

Appendix II : Custody Record Analysis

Background

As part of the inspection of Tower Hamlets Borough police custody cells, a sample of the custody records of detainees held between 6 June and 18 July 2009 were analysed. Custody records were held electronically on NSPIS. A total sample of 40 records were analysed from across the Tower Hamlets area:

Custody suite	Number of records analysed
Bethnal Green	20
Limehouse	10
TOTAL	30

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

Demographic information

- Six (20%) detainees were female and 24 (80%) were male.
- Five people (17%) under the age of 17 were included in the sample.
- Five (17%) detainees were White British and 20 (67%) were from a black and minority ethnic background.
- Nineteen (63%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. Three (10%) had been held for more than 24 hours.

Removal of clothing

- Two detainees had had clothing removed from them:
 - One detainee had had her outer clothing removed (a hooded top with cord). There was no record of whether this was replaced and an alternative provided.
 - One detainee had had all his clothes removed and had been given 'appropriate clothing'. His family was then later allowed to bring him clothes.

Young people

Appropriate adults had been requested for all five young people in our sample. For one of these young people, there appeared to be confusion about who would be his appropriate adult. Both parents were named with different telephone numbers and a foster carer. Appropriate adults were provided for his interview and rights. Another two were cautioned and the appropriate adults were their parents, who took their children home. Most appropriate adults were family members. The three young people interviewed had an appropriate adult present, but one was given their rights without an appropriate adult.

Interpreters

One detainee who struggled with English was booked in and given right using a professional telephone interpreting service. Three other detainees could not speak English at all. One had

an interpreter for interview, but not for his foreign national rights. One had the rights given while an interpreter was present, but it was unclear from the record whether an interpreter was present during the interview. For the last one, there was no evidence of the use of any interpretation for his entire stay in custody.

Immigration detainees

- Ten of our sample were immigration detainees:
 - In one case, the detainee asked for his embassy to be contacted. Unfortunately, the Romanian Embassy did not answer the telephone, but custody staff had made several attempts to contact them.
 - Another detainee who arrived as a suspected illegal immigrant was held overnight while frequent calls were made to UKBA. However, these calls were not answered by UKBA and multiple calls had to be made before a response was given.

Inspector reviews

Inspector reviews were held in line with requirements. Some of these held information that appeared to conflict (e.g. detainee reminded of his legal rights...detainee not roused for review).

Services

- None of the detainees in Limehouse had been offered the services of a drugs worker, but three (15%) of the Bethnal Green detainees had had contact, or an offer of contact, with the drugs worker.
- One detainee asked for and was given a shower. Another detainee, who had been in custody for 47 hours, asked three times for a shower and a clean T-shirt. His initial request was made in the middle of the day before court. He repeated the request with timely gaps and was not granted either a shower or a clean shirt.
- Nobody was given exercise and nobody requested exercise.
- The majority, 25 (83%), of detainees had no record of telephone calls on their record. Two (7%) others had to ask for calls and the last three were offered calls (10%).
- In terms of legal advice, 17 detainees (57%) had no record of being offered legal advice directly and no legal advice was given. In all other cases, legal advice was offered (40%), except one that was prompted from a detainee request (3%).
- No detainees shared a cell while in custody.
- No detainees were offered or requested reading material.
- Thirteen (43%) detainees had either requested, or the police requested on their behalf, a FME. Two had left police custody without the doctor arriving. The shortest waiting time was one minute because the doctor was on site; the longest was four hours. The average waiting time was 1.5 hours. One detainee saw the FME on multiple occasions for the management of his diabetes. This was dealt with well by staff, who made frequent entries about his care on the record.
- Ten (33%) detainees had eaten at least one meal while in custody. Three (10%) other detainees 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 recorded as even offered. One detainee was held for about 50 hours with only three meals received, and one meal refused; his average time between meals was 17 hours.

Additional points of note

- NSPIS automatically promoted staff to check whether females arriving in custody wanted to speak to a female member of staff in private.
- There was a pre-release risk assessment that appeared to be generated by NSPIS, but not on all records. It was often not completed, or showed no risk, when there may have some, e.g. one female detainee who had been in the station about four hours was released to go home at 9.34pm with 'no risk apparent'. She had had a record of self-harm, was taking medication, had mental health problems and had been intoxicated on arrival.
- On a couple of occasions, women's cells had been used for young male detainees, as the custody suite was full at Bethnal Green. Another custody record was delayed in being opened because a cell could not be located for the detainee on arrival.
- A couple of custody records were unclear about when custody ended (i.e. there was no statement about where or when the detainee left). There was also a custody record in which the eventual removal of cuffs, ordered to remain on at the desk, was not recorded.
- Some custody records showed clear consideration for detainees, when planning the timing of the interviews, to stop repeated interviewing and interviewing in the evening, to allow the detainee to rest and eat.

Appendix III : Prisoner survey methodology

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

Choosing the sample size

The survey was conducted on 21 July 2009. A list of potential respondents to have passed through Limehouse or Bethnal Green police stations was created, listing all those who had arrived from Stratford or Thames Magistrates court within the past two months.

Selecting the sample

In total, 111 respondents were approached. Fifty-three respondents reported either being held in police stations outside Tower Hamlets and three could speak no English so it was impossible to determine the police station they had been in. On the day, the questionnaire was offered to 55 respondents; there were five refusals, seven questionnaires were returned blank and there were four non-returns. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, two respondents were interviewed.

Methodology

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

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

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

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

Response rates

In total, 39 (71%) respondents completed and returned their questionnaires.

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 12 police areas since April 2008.

In the comparator document, statistical significance is used to indicate whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading. Orange shading has been used to show a significant difference in prisoners' background details.

Summary

In addition, a summary of the survey results is attached. This shows a breakdown of responses for each question. Percentages have been rounded and therefore may not add up to 100%.

No questions have been filtered within the summary so all percentages refer to responses from the entire sample. The percentages to certain responses within the summary, for example 'Not held over night' options across questions, may differ slightly. This is due to different response rates across questions, meaning that the percentages have been calculated out of different totals (all missing data is excluded). The actual numbers will match up as the data is cleaned to be consistent.

Percentages shown in the summary may differ by 1 or 2% from that shown in the comparison data as the comparator data has been weighted for comparison purposes.

Police Custody Survey

Section 1: About you

- Q2 What police station were you last held at?
Not recorded – 1 (3%); Bethnal Green – 26 (67%); Limehouse – 12 (31%)
- Q3 What type of detainee were you?
Police detainee 79%
Prison lock-out (i.e. you were in custody in a prison before coming here) 8%
Immigration detainee 5%
I don't know 8%
- Q4 How old are you?
16 years or younger 0% 40-49 years 13%
17-21 years 15% 50-59 years 0%
22-29 years 41% 60 years or older 0%
30-39 years 31%
- Q5 Are you:
Male 100%
Female 0%
Transgender/Transexual 0%
- Q6 What is your ethnic origin?
White - British 23%
White - Irish 0%
White - Other 10%
Black or Black British - Caribbean 18%
Black or Black British - African 10%
Black or Black British - Other 0%
Asian or Asian British - Indian 5%
Asian or Asian British - Pakistani 5%
Asian or Asian British - Bangladeshi 18%
Asian or Asian British - Other 0%
Mixed Race - White and Black Caribbean 10%
Mixed Race - White and Black African 0%
Mixed Race - White and Asian 0%
Mixed Race - Other 0%
Chinese 0%
Other ethnic group 0%
Please specify:
- Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?
Yes 14%
No 86%
- Q8 What, if any, would you classify as your religious group?
None 8%

Church of England.....	33%
Catholic.....	15%
Protestant	5%
Other Christian denomination	5%
Buddhist.....	0%
Hindu	3%
Jewish.....	0%
Muslim	31%
Sikh.....	0%
Any other religion, please specify	

Q9	How would you describe your sexual orientation?	
	Straight/Heterosexual	100%
	Gay/Lesbian/Homosexual	0%
	Bisexual	0%
	Other (please specify):	
Q10	Do you consider yourself to have a disability?	
	Yes	18%
	No	77%
	Don't know	5%
Q11	Have you ever been held in police custody before?	
	Yes	95%
	No	5%

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?	
	1 hour or less.....	0%
	More than 1 hour, but less than 6 hours.....	3%
	More than 6 hours, but less than 12 hours	5%
	More than 12 hours, but less than 24 hours	23%
	More than 24 hours, but less than 48 hours (2 days)	31%
	More than 48 hours (2 days), but less than 72 hours (3 days)	28%
	72 hours (3 days) or more	10%
Q13	Were you given information about your arrest and your entitlements when you arrived there?	
	Yes	77%
	No	15%
	Don't know/Can't remember	8%

Q14	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?			
	Yes		56%	
	No		33%	
	I don't know what this is/I don't remember.....		10%	
Q15	If your clothes were taken away, were you offered different clothing to wear?			
	My clothes were not taken.....		42%	
	I was offered a tracksuit to wear		22%	
	I was offered an evidence suit to wear		22%	
	I was offered a blanket		14%	
Q16	Could you use a toilet when you needed to?			
	Yes		87%	
	No		13%	
	Don't know		0%	
Q17	If you have used the toilet there, were these things provided?			
		Yes	No	
	Toilet paper	44%	56%	
Q18	Did you share a cell at the police station?			
	Yes		3%	
	No		97%	
Q19	How would you rate the condition of your cell:			
		Good	Neither	Bad
	Cleanliness	26%	24%	50%
	Ventilation/Air Quality	32%	24%	45%
	Temperature	19%	28%	53%
	Lighting	41%	30%	30%
Q20	Was there any graffiti in your cell when you arrived?			
	Yes		81%	
	No		19%	
Q21	Did staff explain to you the correct use of the cell bell?			
	Yes		21%	
	No		79%	
Q22	Were you held overnight?			
	Yes		100%	
	No		0%	
Q23	If you were held overnight, which items of clean bedding were you given?			
	Not held overnight		0%	
	Pillow		25%	
	Blanket.....		50%	
	Nothing		25%	

Q24	Were you offered a shower at the police station?		
	Yes		5%
	No		95%
Q25	Were you offered any period of outside exercise while there?		
	Yes		3%
	No		97%
Q26	Were you offered anything to:	Yes	No
	Eat?	95%	5%
	Drink?	92%	8%
Q27	Was the food/drink you received suitable for your dietary requirements?		
	I did not have any food or drink		23%
	Yes		31%
	No		46%
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?		
	I do not smoke		22%
	I was allowed to smoke		3%
	I was not offered anything to cope with not smoking		75%
	I was offered nicotine gum.....		0%
	I was offered nicotine patches		0%
	I was offered nicotine lozenges		0%
Q29	Were you offered anything to read?		
	Yes		3%
	No		97%
Q30	Was someone informed of your arrest?		
	Yes		47%
	No		29%
	I don't know.....		5%
	I didn't want to inform anyone		18%
Q31	Were you offered a free telephone call?		
	Yes		58%
	No		42%
Q32	If you were denied a free phone call, was a reason for this offered?		
	My phone call was not denied		67%
	Yes		3%
	No		31%
Q33	Did you have any concerns about the following while you were in police custody:	Yes	No
	Who was taking care of your children	8%	92%
	Contacting your partner, relative or friend	39%	61%
	Contacting your employer	23%	77%

Where you were going once released 26% 74%

Q34 Were you interviewed by police officials about your case?
 Yes 95%
 No 5% If No, go to Q35

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

	Yes	No	Not needed
Solicitor	74%	17%	9%
Appropriate Adult	11%	33%	56%
Interpreter	5%	35%	60%

Q36 How long did you have to wait for your solicitor?
 I did not requested a solicitor 26%
 2 hours or less 8%
 Over 2 hours but less than 4 hours 18%
 4 hours or more 47%

Q37 Were you officially charged?
 Yes 97%
 No 3%
 Don't know 0%

Q38 How long were you in police custody after being charged?
 I have not been charged yet 3%
 1 hour or less 5%
 More than 1 hour, but less than 6 hours 5%
 More than 6 hours, but less than 12 hours 27%
 12 hours or more 59%

Section 3: Safety

Q40 Did you feel safe there?
 Yes 51%
 No 49%

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?
 Yes 43%
 No 57%

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

I have not been victimised	45%	Because of your crime	11%
Insulting remarks (about you, your family or friends)	13%	Because of your sexuality	0%
Physical abuse (being hit, kicked or assaulted)	11%	Because you have a disability	0%
Sexual abuse	2%	Because of your religion/religious beliefs	2%

Your race or ethnic origin 6% Because you are from a different part of the country than others 2%

Drugs 9%

Please describe:

- Q43 Were you handcuffed or restrained while in the police custody suite?
 Yes 57%
 No 43%
- Q44 Were you injured while in police custody in a way that you feel was not your fault?
 Yes 24%
 No 76%
- Q45 Were you told how to make a complaint about your treatment here, if you needed to?
 Yes 14%
 No 86%

Section 4: Healthcare

- Q47 When you were in police custody were you on any medication?
 Yes 35%
 No 65%
- Q48 Were you able to continue taking your medication while there?
 Not taking medication 65%
 Yes 11%
 No 24%
- Q49 Did someone explain your entitlements to see a healthcare professional, if you needed to?
 Yes 33%
 No 58%
 Don't know 8%
- Q50 Were you seen by the following healthcare professionals during your time there?
- | | Yes | No |
|--------------|-----|-----|
| Doctor | 57% | 43% |
| Nurse | 9% | 91% |
| Paramedic | 5% | 95% |
| Psychiatrist | 5% | 95% |
- Q51 Were you able to see a healthcare professional of your own gender?
 Yes 21%
 No 47%
 Don't know 32%
- Q52 Did you have any drug or alcohol problems?
 Yes 59%
 No 41%

Q53	Did you see, or were you offered the chance to see, a drug or alcohol support worker?						
	I didn't have any drug/alcohol problems	42%					
	Yes	22%					
	No	36%					
Q54	Were you offered relief or medication for your immediate symptoms?						
	I didn't have any drug/alcohol problems	43%					
	Yes	20%					
	No	37%					
Q55	Please rate the quality of your healthcare while in police custody:						
		I was not seen by health - care	Very Good	Good	Neither	Bad	Very Bad
	Quality of healthcare	43%	3%	20%	11%	11%	11%
Q56	Did you have any specific physical healthcare needs?						
	No	67%					
	Yes	33%					
	Please specify:					100%	
Q57	Did you have any specific mental healthcare needs?						
	No	76%					
	Yes	24%					
	Please specify:					100%	

Section 5: Prison lock-out information

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

Q59	Were you told that you would be held in a police station, rather than a prison, before you arrived there?	
	Yes	21%
	No	79%
Q60	How long did you spend in the escort van before arriving there?	
	Less than 1 hour.....	39%
	More than 1 hour, but less than 2 hours	35%
	More than 2 hours, but less than 3 hours	4%
	More than 3 hours, but less than 4 hours	9%
	More than 4 hours	13%
Q61	Were you offered the chance to let family/friends know where you were?	
	Yes	43%
	No	57%
Q62	Did your property come with you to the police station?	
	Yes	70%
	No	26%

I don't know..... 4%

Q63 On average, how much time were you able to spend out of your police cell each day?

I was not able to spend any time out of my police cell	71%
Less than 1 hour.....	10%
More than 1 hour, but less than 2 hours.....	0%
More than 2 hours, but less than 3 hours	0%
More than 3 hours, but less than 4 hours	14%
More than 4 hours	5%



Prisoner Survey Responses for Tower Hamlets 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

		Tower Hamlets	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		39	379
SECTION 1: General Information			
2	Are you a Police detainee?	79%	86%
3	Are you under 21 years of age?	16%	10%
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)	66%	39%
6	Are you a foreign national?	14%	17%
7	Are you Muslim?	30%	13%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	18%	17%
10	Have you been in police custody before?	94%	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?	70%	63%
12	Were you given information about your arrest and entitlements when you arrived?	76%	72%
13	Were you told about PACE?	56%	54%
14	If your clothes were taken away, were you given a tracksuit to wear?	37%	43%
15	Could you use a toilet when you needed to?	88%	88%
16	If you did use the toilet, was toilet paper provided?	44%	56%
17	Did you share a cell at the station?	2%	4%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	27%	26%
18b	Ventilation/air quality?	31%	17%
18c	Temperature?	20%	13%
18d	Lighting?	40%	44%
19	Was there any graffiti in your cell when you arrived?	81%	59%
20	Did staff explain the correct use of the cell bell?	20%	22%
21	Were you held overnight?	100%	89%
22	If you were held overnight, were you given no clean items of bedding?	30%	34%
23	Were you offered a shower?	6%	8%
24	Were you offered a period of outside exercise?	2%	6%

Key to tables

		Tower Hamlets	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		
25a	Were you offered anything to eat?	94%	76%
25b	Were you offered anything to drink?	92%	80%
26	Was the food/drink you received suitable for your dietary requirements?	41%	39%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	75%	76%
28	Were you offered anything to read?	2%	12%
29	Was someone informed of your arrest?	47%	42%
30	Were you offered a free telephone call?	58%	51%
31	If you were denied a free call, was a reason given?	7%	20%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	9%	21%
32b	Contacting your partner, relative or friend?	40%	55%
32c	Contacting your employer?	24%	24%
32d	Where you were going once released?	26%	37%
34	If you were interviewed were the following people present:		
34a	Solicitor	73%	76%
34b	Appropriate adult	13%	6%
34c	Interpreter	4%	10%
35	Did you wait over 4 hours for your solicitor?	64%	64%
37	Were you held 12 hours or more in custody after being charged?	61%	65%
SECTION 3: Safety			
39	Did you feel unsafe?	49%	41%
40	Has another detainee or a member of staff victimised you?	43%	45%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	17%	28%
41b	Physical abuse (being hit, kicked or assaulted)	13%	16%
41c	Sexual abuse	2%	2%
41d	Your race or ethnic origin	8%	7%
41e	Drugs	11%	17%
41f	Because of your crime	13%	21%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	0%	3%
41i	Because of your religion/religious beliefs	2%	5%
41j	Because you are from a different part of the country than others	2%	6%
42	Were you handcuffed or restrained whilst in the police custody suite?	57%	48%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	25%	29%
44	Were you told how to make a complaint about your treatment?	13%	12%

Key to tables

	Any percent highlighted in green is significantly better	Tower Hamlets	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Healthcare			
46	Were you on any medication?	35%	44%
47	For those who were on medication: were you able to continue taking your medication?	29%	39%
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	33%	36%
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	58%	51%
49b	Nurse	10%	16%
49c	Paramedic	4%	2%
49d	Psychiatrist	4%	3%
50	Were you able to see a healthcare professional of your own gender?	21%	29%
51	Did you have any drug or alcohol problems?	60%	57%
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?	37%	41%
53	Were you offered relief medication for your immediate symptoms?	35%	34%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	40%	30%
55	Do you have any specific physical healthcare needs?	33%	35%
56	Do you have any specific mental healthcare needs?	25%	24%