



Inspecting policing
in the public interest

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

6 – 8 July 2009

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Crown copyright 2009

Printed and published by:

Her Majesty's Inspectorate of Prisons
And Her Majesty's Inspectorate of Constabulary

Ashley House
Monck Street
London
SW1P 2BQ
England

Contents

1. Introduction	5
2. Background and key findings	7
3. Strategy	11
4. Treatment and conditions	15
5. Individual rights	23
6. Healthcare	27
7. Summary of recommendations	33
Appendices:	
I Inspection team	39
II Summary of detainee questionnaires and interviews	40

1. Introduction

This inspection of police custody suites in the London Borough of Ealing 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.

Ealing has two custody suites, Southall and Acton, designated under the Police and Criminal Evidence Act (PACE) 1984 for the reception of detainees. A third suite in Ealing is mothballed. Both Acton and Southall are open 24 hours a day and may hold adults, juveniles and immigration detainees. Some 5,421 detainees were held in the six months preceding the inspection. As well as visiting the suites, inspectors interviewed a sample of prisoners at HMP Wormwood Scrubs who had previously been detained in Southall or Acton.

Strategic management was provided by the custody directorate of the Metropolitan Police Service (MPS), with day-to-day management devolved to the borough commander and his staff. The custody directorate operated an internal inspection function. Responsibility for the custody estate lay with the Metropolitan Police Authority (MPA). The MPA did not have a single custody lead, but one official did manage the Independent Custody Visitors (ICVs). The ICVs reported good relationships with custody managers and staff.

A detective superintendent provided highly visible day-to-day management of the suites and overall supervision was generally sound. Staffing at both suites was now permanent, although there were staff vacancies. There were good partnerships with health service providers and an improving relationship with the Crown Prosecution Service.

Custody staff were observed to be generally polite and professional in the treatment of detainees. Nevertheless, above average numbers of detainees in our survey reported feeling unsafe. Conditions were generally adequate, although communal areas in Southall required deep cleaning, mattresses were not always clean and only paper towels were issued for those requiring a shower. There was also little privacy when booking in and no cells were adapted for those with disabilities. There were large numbers of detainees with limited English and more use needed to be made of professional translation services. There did not appear to be an overuse of force, but recording was limited.

There was appropriate attention to the entitlements of detainees under PACE. Solicitors were positive about how staff treated them and detainees. There were some difficulties in accessing appropriate adults and staff complained of long delays by the UK Border Agency in visiting immigration cases. Local court cut-off times and a lack of video link facilities hampered expeditious processing of detainees. The quality of custody records varied.

Health services were generally good, although there were some serious delays in the arrival of forensic medical examiners (FMEs) after being called, and contract monitoring was weak. Medicines management was adequate. FME access to clinical records was not comprehensive, and record keeping itself was inconsistent. A good drug support service was provided, although there was no specific provision for those with alcohol problems. Effective support was provided by the local mental health trust.

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

This inspection revealed an essentially positive picture of police custody in Ealing, with generally sound management and competent staff delivering a professional service. There are a number of areas that we identify as requiring further improvement but, overall, there was much to commend.

Denis O'Connor
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 safer detention and handling of person in police custody guide, and focus on outcomes for detainees. They are also 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 inspection was conducted at Acton and Southall custody suites in the London Borough of Ealing. 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 Wormwood Scrubs who had formerly been detained in Acton and Southall 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). A third custody suite at Ealing police station had been mothballed.
- 2.4 Acton and Southall custody suites were open 24 hours a day and held adults and juveniles. Southall was the designated suite for immigration detainees. The suites had received 5,421 detainees in the six months to 31 March 2009. This included 709 juveniles, 663 women and 154 immigration detainees.

Strategic overview

- 2.5 The MPS custody directorate within the Operation Emerald territorial policing team had strategic over-sight 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 in the Ealing borough was managed by a detective superintendent who held the criminal justice portfolio. He was an extremely visible presence in the two custody suites. A chief inspector had responsibility for ensuring that all procedures and practices dictated by Emerald were in place, supported by a full-time inspector who was the dedicated day-to-day manager of custody at Acton and Southall. Performance was assessed by exception reporting, which meant that problems or difficulties needed to be actively brought to the attention of senior managers for them to be addressed or dealt with.
- 2.8 The staffing model at both custody suits utilised permanent staff, although this had only very recently been introduced at Southall. There were some vacancies for police custody sergeants and other detention staff. Custody sergeants attended four training sessions a year dedicated to custody issues. Ad hoc training in relevant areas was also offered to all staff. Senior managers said they were cascading Independent Police Complaints Commission (IPCC) lessons learned bulletins, but staff working in custody were not aware of these.
- 2.9 Some positive partnership work had been developed with local mental health providers, including seconding a police member of staff to the relevant trust. Plans were advanced to introduce on-site nurse practitioners at both custody suites. Relationships with the Crown Prosecution Service (CPS) were developing after some challenging issues had been resolved.
- 2.10 There was no strategic steer on the use of force and no management information was being collected to enable senior management monitoring and oversight. Record keeping was particularly poor.

Treatment and conditions

- 2.11 Custody staff were generally polite to detainees, but booking in took place with little privacy. Not all custody staff were aware of the different needs of female detainees and, apart from the provision of appropriate adults, juveniles were not treated differently to others. A significant number of detainees did not speak English, but professional telephone interpreting services were not used during booking in to ensure they understood their rights and could contribute to risk assessments. Interpreters were used particularly for formal police interviews. There was little information or advice for foreign national detainees subject to deportation. No cells were adapted for use by detainees with disabilities.
- 2.12 Risk assessments were completed on arrival and, where necessary, subsequently changed to reflect new information. All staff carried anti-ligature cutters. Designated detention officers (DDOs) were aware of the need to vary the frequency and timing of observations of vulnerable detainees, but police constable (PC) gaolers less so. Not all PC gaolers had been trained in fire evacuation and there were general issues about PC gaolers not getting the training they needed to carry out their duties adequately. In our survey, more detainees than the comparator said they felt unsafe in detention and had been victimised by another detainee or member of staff. While we could not explain these perceptions, managers needed to assess why they might exist and whether any remedial action was necessary.
- 2.13 Custody records did not show that force was overused, but there was no clear definition of what was meant by a use of force incident and when it might be of concern. There was no central record of use of force. We were told that incapacitants and Tasers were not used, but one member of staff carried a spray and said he would use it if necessary. Some custody records did not make clear when handcuffs had been applied or removed.

- 2.14 Acton was generally clean, but some communal areas at Southall needed deep cleaning. All suites were no smoking areas. Use of cell bells was explained to detainees, but some were muted inappropriately. Mattresses and pillows were routinely provided, but not all mattresses were wiped down when cells were vacated. Showers were offered only on request and only inadequate paper towels were provided. Toilets were provided in cells, but hand washing facilities were not.
- 2.15 Paper suits were used at Acton when clothes were removed and no underwear was provided. Detainee meals were provided from station canteens, although choice was limited, and drinks were regularly offered. Neither suite had an exercise yard. Only limited reading materials were available and detainees could not have visits.

Individual rights

- 2.16 Custody sergeants ensured there was sufficient grounds for arrest and gave examples of detainees being released when this was not the case. Details of rights and entitlements were available in a range of languages, but not large print. Detainees were offered a free telephone call, although these could not be made in private. Custody was rarely used as a place of safety for children and young people under section 46 of the Children's Act. Staff described long delays with the UK Border Agency (UKBA) visiting for immigration cases. Detainees were asked about dependency obligations and attempts were made to facilitate these, including the use of bail.
- 2.17 A duty solicitor scheme operated and consultations took place in private. Solicitors were positive about how staff treated them and detainees. The appropriate adult scheme provided a 24-hour service, but there were some significant delays in them arriving once requested. Custody records contained several examples where an appropriate adult was needed, but attendance had not been recorded. Up-to-date copies of the PACE codes of practice were offered to detainees. Custody records did not indicate that detainees were interviewed while under the influence of alcohol or drugs and showed that eight-hour continuous breaks were adhered to when appropriate.
- 2.18 There was no video link facility. Weekday court cut-off times meant some detainees spent longer in custody than would otherwise be the case. Detainees were not told how to complain and anyone who wanted to had to complain at the station front desk on release. There were examples of poor record keeping in custody records.

Healthcare

- 2.19 The management and recording of medicines was adequate, but there had been significant delays in the supply of stock after orders had been placed. Doctors therefore carried their own stock of medicines and wrote individual prescriptions, which caused additional work for custody staff and resulted in delays. General prescriptions had also been written to cover these shortfalls.
- 2.20 There were unacceptable delays in forensic medical examiners (FMEs) arriving after being called. Monitoring of the contract was not local. There were very few female doctors available. Examination rooms were basic, containing little if any medical equipment. Detainees were interviewed by FMEs with the consultation door open. Record keeping was inconsistent. Some FMEs still did not have access to the national strategy for police information systems (NSPIS) so a complete clinical record of all detainees' treatment was not always available on the

custody record. Some paper records were kept, which often duplicated the NSPIS record and were not confidentially stored.

- 2.21 A drug referral scheme provided direct and timely referrals to community-based services. No alcohol service was offered. Workers did not give out needles or syringes, but would advise detainees where they could be obtained.
- 2.22 Section 136 detainees were rarely if ever held in police custody. There were good arrangements with the local mental health trust for these detainees and staff were aware of how to deal with detainees arrested.

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 led by a commander. Day-to-day management was delivered by a detective superintendent. There was an internal inspection function. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and accountability therefore rested with the borough commander, who was a chief superintendent. There was no defined MPA lead for custody, but a MPA official managed the ICV scheme and had lead responsibility for reporting on custody issues.
- 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, including use of police custody, use of closed-circuit television (CCTV) and guidance to custody staff on the supervision of detainees. They were designed to assist boroughs to deliver consistent levels of service, although responsibility and accountability for their delivery had been delegated to borough commanders.
- 3.4 The MPS had recruited its first team of nurses to complement the level of healthcare provided by its doctors. The aim was to recruit 200 nurses by 2012 to ensure that each borough had a nurse on duty 24 hours a day. They were not yet available at Ealing, although the borough commander expected them to arrive within six months. The issue of clinical governance was being revisited with a view to employing a full-time member of staff.
- 3.5 Ealing borough had three custody suites. Acton was the main custody suite. Southall was a smaller custody suite used mainly for detainees suspected of involvement in domestic violence and as an overflow facility for when Acton reached full capacity. Ealing was a mothballed site and had recently been refurbished by the Home Office in relation to Operation Safeguard. It was not used for any mainstream policing detainees and had not been used for Operation Safeguard for some considerable time.
- 3.6 The borough commander believed the borough had a strong chain of command reinforced by oversight mechanisms that allowed custody issues to be highlighted and tracked. Members of the senior management team (SMT) were encouraged to visit the custody suites as often as possible and there was strong evidence of SMT involvement, with intrusive supervision displayed in particular by the detective superintendent. However, the business model used was one of exception reporting, which relied on a clear picture of custodial issues being presented to the SMT by exception reports having successfully made their way up through the chain of command or by having them brought to the attention of the SMT by another oversight mechanism, for example the daily management meeting.

- 3.7 The borough had monthly performance framework meetings, which included Criminal Justice as a standing item, but custody was not an agenda item in itself. A Criminal Justice Unit (CJU) meeting drove CJU targets, which were not specific to custody. Custody managers' meetings and health and safety meetings looked to identify trends or patterns of concern in custody suites and daily management meetings picked up issues on a daily basis. We were not convinced that this model allowed the SMT a rounded view of performance in custody suites as it could lend itself to focusing on tactical operational outcomes of individual cases at the expense of more strategic custodial issues.
- 3.8 All custody sergeants and designated detention officers (DDOs) had received nationally approved custody training before being deployed in custody suites. Custody training for sergeants and DDOs was delivered corporately. Custody training for police constable (PC) gaolers was delivered locally, but some had not received custody-specific training, which increased risks for detainees and the MPS. The custody teams in the custody suites were permanent teams, with police sergeants 'posted' into the roles, and the custody manager had recently been tasked by the borough commander to match resources more closely to demand.
- 3.9 There were good local partnerships with the National Health Service and Mental Health Trust. A police inspector was based in the West London Alliance to formalise policies and protocols. This post was part funded by the Mental Health Trust. The borough commander believed that the borough received good support from social services when appropriate adults (AAs) were required for vulnerable adults and juveniles detained in custody. However, a number of custody records highlighted the need for an AA, but did not record that one had actually attended. Record-keeping was so poor that we had to request audio recordings of interviews to be certain that AAs had been present.
- 3.10 We formally requested that one custody record be reviewed by the Department for Professional Standards as the entries by the custody sergeant about the behaviour and consequent treatment of one detainee did not concur and were at odds with the entries made by a PC gaoler. Cross-referencing of the closed-circuit television (CCTV) footage did not ease our concerns. We await a formal response on this case from the borough.
- 3.11 The borough commander described good relations with the Crown Prosecution Service (CPS). He was keen to have an integrated prosecution team based at Acton, but progress had stalled due to a lack of resources within the CPS. He described the police and CPS teams as supportive of each other and said their relationship was improving. There were no reported delays in CPS advice being provided to the police. There was no formal forum for defence solicitors to feed their concerns into, although the borough commander relied on the ICVs to ensure that detainees were properly treated and said defence solicitors could feed any concerns into the local criminal justice board meetings.
- 3.12 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigations into adverse incidents. Adverse incidents were referred to as 'successful interventions' to encourage reporting and create a positive learning environment. However, custody sergeants we spoke to were unaware of the 'lessons learned' literature from the IPCC and did not know how to access it. There was no evidence that custody staff understood the document on SDHP or the expectations that flowed from it.
- 3.13 There was a MPA lead for the ICV scheme, which provided an important independent oversight mechanism. The borough commander reported good relationships with ICVs, which was echoed by the ICV chair. The head of custody attended ICV meetings and the borough commander relied on the head of custody to highlight issues to be addressed. ICVs visited the

custody suites regularly and aimed to increase their weekly visits. Their reports focused on detainee welfare, with ICVs prepared to seek assurance on issues of concern. There was a sound system (Excel spreadsheets) for recording these and a formal mechanism for feedback where the custody manager regularly attended meetings with ICVs to provide updates on concerns raised by them.

- 3.14 The borough commander said complaints were looked at centrally on behalf of the borough, although he said the local learning and development discipline unit monitored complaints for trends, such as excessive use of force, that triggered an intervention programme. There was no formal feedback loop from the central Department for Professional Standards to boroughs on the number or type of complaint made by detainees. This strategic weakness failed to identify opportunities for learning or problem-solving opportunities in respect of dealing with the underlying causes of complaints.
- 3.15 With the exception of the use of firearms and Tasers, which were referred to the IPCC, there was no monitoring of use of force either at a local or force wide level. The custody manager said use of force was noted in individual records and sometime in individual officer's evidence records. It was therefore not possible to identify any particular concerns about use of force, such as whether any ethnic groups were over-represented in its use or whether some individual officers were more likely to use force than others.

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 The Metropolitan Police Service should establish a formal mechanism to ensure that boroughs comply with the findings of internal inspection within agreed timelines.
- 3.18 The current business model of reporting by exception for Ealing borough should be reviewed to ensure the senior management team has a clearer picture of performance within its custody suites. Custody performance should be a standing agenda item on the performance framework.
- 3.19 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.
- 3.20 Regular and intrusive dip-sampling of custody records should take place that identifies and addresses poor record-keeping. These checks should be cross-referenced with close-circuit television footage as an additional safeguard.
- 3.21 Police officers and staff should access the 'lessons learned' circular from the Independent Police Complaints Commission.
- 3.22 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.

- 3.23 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.

To the Metropolitan Police Authority

- 3.24 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.

Respect

- 4.1 Staff treated detainees politely and with respect. The layout of the custody area afforded little privacy, particularly at Acton where several detainees could be booked in at the same time. There were no partitions between the booking in points and all conversations between custody sergeants and detainees could be overheard by others in the area.
- 4.2 Women were given the opportunity to speak in private to a female officer unrelated to their case. Rub-down and, if required, strip searches of female detainees were conducted by female officers.
- 4.3 Provision for detainees who did not speak English was poor, with no access to a specialist telephone interpreting service. There was a list of interpreters and staff said some were prepared to interpret over the telephone, but this covered few languages and was rarely used. A number of police officers could speak different languages and were sometimes asked to interpret and obtain risk assessment information. Copies of the rights and entitlements leaflet were available in several languages from the intranet (see also paragraph 5.5) and foreign nationals were asked if they wished their embassy or consulate to be informed of their situation. Official interpreters were also used, but a number of custody records that indicated the detainee had difficulty understanding English did not record that an interpreter had been used. A German man being booked in repeatedly said he could not understand what was being said and could not read English well. Despite this, the booking in and risk assessment were conducted in English and he was asked to read and sign several sheets of information without help from an interpreter or telephone interpreting service. He was given a copy of the rights and entitlement leaflet in German, but there were no books, newspapers or magazines in languages other than English.
- 4.4 There were no special arrangements for immigration detainees. Custody sergeants did not have a list of specialist immigration solicitors or sources of immigration legal and bail advice, but said this information was available from the duty solicitor.
- 4.5 There was a comprehensive supply of religious material and books, including a Bible, a Qu'ran in English and Arabic, the Bhagavad Gita and a book of Sikh teachings. Prayer mats were also available. Designated detention officers (DDOs) and police constable (PC) gaolers carried a compass to help detainees identify the direction of Mecca. Staff had recently completed an e-learning package on diversity.
- 4.6 Both suites were at ground floor level with suitable access from the vehicle yard. Acton had a toilet for use by detainees with a physical disability. This was appropriately equipped, but the door had been fitted the wrong way and had the observation flap on the inside. None of the cells had been adapted for use by detainees with disabilities. The bed plinths at Acton were very low and therefore difficult for a detainee with limited mobility to use. Staff said they could print off the rights and entitlements leaflet in large print if required, but we were not shown any information in Braille. Custody sergeants said they would read information to any detainee who

had sight impairment or difficulty reading. Details of a sign language interpreter were displayed at Acton, but staff could not recall having to use this service.

- 4.7 All juveniles were routinely placed on 30-minute observations and in cells nearest the custody desk. Appropriate adults were not allowed to sit with them in cells, but one 15 year-old young man was allowed to wait with his mother and sister in the booking in area. Apart from this, children and young people were treated in the same way as adults. There were no age-appropriate activities such as books, magazines or activity books. Custody sergeants said they would contact the child protection unit at Acton if they had any concerns. During our night visit, a 17 year-old young woman was interviewed without an appropriate adult present.

Safety

- 4.8 Detainees were asked about any history or thoughts of self-harm during the risk assessment. Custody sergeants also assessed risk based on the detainee's behaviour at the time of the arrest, their demeanour on arrival at the custody suite and any information contained on computer records before deciding on the level of observation required. This was recorded on the custody record and reviewed if the detainee's behaviour changed, although there was little understanding of what could potentially trigger a raised level of risk. DDOs were aware that observations of detainees at risk should be unpredictable, but PC gaolers said they would complete checks on the hour or half hour.
- 4.9 Dedicated custody staff received specific suicide and self-harm prevention training, but were not aware of the Home Office safer detention guidance, instead relying on guidance issued by Emerald. All custody staff carried ligature cutters, but had not been told how to use them. They were aware that used cutters should be bagged and tagged as evidence and replaced. Near miss forms showed that staff routinely responded to a self-harm attempt by removing the detainee's clothing and giving them a paper suit or blanket. This was the case even for one detainee who staff believed was only attention seeking. In one incident where a detainee tied a cord around her neck, staff had cut the cord using a ligature cutter and the custody sergeant had instructed four female officers to remove all her clothing. The detainee was then given a blanket and placed under constant observation by CCTV.
- 4.10 Custody sergeants also assessed a detainee's risk to others and anyone deemed to present such a risk was booked in separately. All detainees were given a rub down search on arrival and checked using a metal detector. Anyone suspected of carrying a weapon or drugs was strip searched. Detainees were not required to share a cell and juveniles and women were located away from adult male detainees wherever possible. In our survey, 60% of detainees, against a comparator of 39%, said they felt unsafe in the custody suite and 68% that they had been victimised by a detainee or member of staff.

Use of force

- 4.11 Only handcuffs and leg restraints were kept in the custody suites. There was no central log of their use. There was no clear agreed definition of the use of force and no criteria for when it should be recorded. Most officers described force as any occasion when they had to lay hands on a detainee, even if this comprised a gentle push to get a recalcitrant detainee into a cell. However, all agreed that only the more serious use of force, such as that leading to an injury, would be recorded in the custody record. In such cases, a report was made to the FME, but there was no clear guidance setting out the level of use of force that would require a detainee to be seen by a healthcare professional. Without a central log, it was impossible for managers

to satisfy themselves that it was done in all cases. The attendance of a FME within two hours could not be relied on.

- 4.12 Almost all uses of force were spontaneous rather than planned. Custody staff said they would consider using force when a detainee was non-compliant, such as refusing to go into a cell, but would first make a dynamic risk assessment of whether it was necessary. They were aware that use of force needed to be reasonable and justifiable and said they would first aim to de-escalate situations. Such individual discretion also applied when dealing with detainees such as pregnant women and those with health problems, for whom there was no formal guidance. One pregnant woman who was threatening and violent had been left in the desk area to cool down rather than taken to her cell using force.
- 4.13 Staff said use of force of any kind was very rare. Custody records included few cases and there was little indication that force was used routinely or unnecessarily. However, one man had arrived in handcuffs at 9.30pm when he was recorded as compliant and was kept in handcuffs until 11.16pm without explanation or justification. In a number of cases, entries detailing the restraints in which detainees were held on arrival were made some time after arrival and after other entries, suggesting that the detainee had remained in restraints until that time. However, discussion of the individual circumstances indicated that this was more usually due to poor recording and there was no other evidence that detainees were unnecessarily handcuffed in custody areas.
- 4.14 The inspector in charge of the custody suites was clear that there were no circumstances in which the use of incapacitant sprays or Taser stun guns was appropriate, but there was no clear guidance to custody staff about this. Most staff said use of either was inappropriate in the confines of a custody suite, but one custody officer at Southall carried CS spray and said he would use it if he believed the circumstances warranted it.
- 4.15 We observed one planned use of force to remove an intoxicated man from his cell, take his finger prints and relocate him in another cell. This was undertaken by a seven-strong team from the territorial support unit wearing protective suits and helmets. We were told that one of the team was a 'medic'. While this was done proficiently and with little difficulty, the detainee in question was asleep and could have been left to see if he was willing to cooperate when he woke up. He was well known to custody staff, one of whom said he was always compliant when he sobered up.
- 4.16 All custody officers received standard police training in use of force backed up by refresher training twice a year. However, training records were not available to confirm this.

Physical conditions

- 4.17 The custody suite at Acton was 3.5 years old, clean and in good condition. Each of the 22 cells contained a low plinth bed and a stainless steel integral toilet. The cell walls were tiled and almost entirely free from graffiti. The suite at Southall was much older. It had 11 cells, all with integral sanitation and a standard height plinth bed. The cells appeared clean, but there was a smell of urine in many areas. Some communal areas were grimy and there was some peeling paint.
- 4.18 A design fault in the cell door observation hatches at both suites meant they continually worked loose, creating a gap that was a potential ligature point. Managers were aware of this. The hatches were checked daily at Acton and any with a gap wider than a two pence piece were taken out of use until the hatch had been tightened by maintenance staff. The PC gaoler

at Southall did not undertake similar checks and a number of hatches were loose. Maintenance appeared to be done when facilities were open. The custody suites were reasonably well maintained and all ligature points had been carefully filled in. Staff said repairs were usually completed within 24 hours of being reported.

- 4.19 All cells were equipped with a call bell and staff said the system was explained to detainees when they were located in a cell. This appeared to be the case for most detainees, but we saw two examples where the system was not explained. In our survey, 21% of detainees said use of the call bell had been explained to them. Call bells were answered promptly during the inspection and staff recorded any issues raised in the custody record. Staff said bells could be muted, usually for persistent abuse and only on the authority of the custody sergeant. However, we found one call bell being muted for little apparent reason. An alarm sounded if a muted call bell had not been reset at the cell door within 10 minutes.
- 4.20 The no smoking policy was strictly enforced. Staff said detainees could not get nicotine replacement products from the doctor while in custody.
- 4.21 Fire evacuation procedures were in place, plans were updated and there had been a number of recent live evacuations. DDOs had been trained in fire evacuation, but there had been no routine fire training for PC gaolers. Fire evacuation guidelines were posted on the wall in the staff area at Acton, but not at Southall. The custody sergeant at Southall was able to explain the evacuation procedures in detail, but the PC gaoler had not been required to read the fire orders or evacuation plan.

Personal comfort and hygiene

- 4.22 All cells contained a wipe clean mattress and pillow. DDOs at Acton cleaned these with a wet wipe after each use, but PC gaolers at both suites were unaware that they should do so. Any damaged or obviously soiled mattress or pillow was replaced. There were adequate supplies of clean blankets and these were given to detainees on request. Used blankets were stored separately and laundered before re-use.
- 4.23 Women were not routinely given hygiene packs. The DDOs and some PC gaolers said they would ask female detainees if they required sanitary products when locating them in a cell, but others said they assumed women would ask if they needed them. There were plentiful supplies of sanitary products in the store rooms. Recently introduced custody suite training specifically addressed issues affecting the safe and dignified detention of women and was in the process of being disseminated to staff.
- 4.24 All cells had integral sanitation, but no hand washing facilities. The toilet areas at Acton were not screened, but spy holes were covered. Cells covered by CCTV had the toilet area excluded from view. Many cells had toilet paper and we saw detainees being given this when located in a cell. Some DDOs told detainees to use the call bell if they needed more toilet paper or to wash their hands, but others did not. At Acton, there was no soap dispenser or soap by the sink even though there were supplies of soap in the store cupboard.
- 4.25 Detainees were not routinely offered a shower and none of those we surveyed said they had received such an offer. Some who had obviously not been able to wash recently were encouraged to shower, but others could use one only on request. There were two shower areas at Acton. These had a half door, but the shower and changing area were inadequately screened so women could shower only if two female staff were available and it was possible to restrict access to the corridor for all detainees and male staff. The one shower at Southall had

no door or partition. It was behind a wall, but anyone in the changing area was in full view of the communal area. There was no seating and nowhere to put clothes while showering. Shampoo and soap was available, but the only towels were large sheets of paper towel, which were inadequate and disintegrated. In our survey, no one said they had been offered a shower. The custody record of one detainee who had arrived on 20 February 2009 showed that he had requested a shower at 2.13pm on 21 February and was eventually allowed one at 9.30am on 22 February.

- 4.26 Both suites had an adequate supply of white t-shirts, tracksuits bottoms and black plimsolls in a range of sizes. Staff at Acton said detainees were issued this clothing only if they were going to court or being released. Other detainees were given white paper evidence suits. At Southall, all detainees whose clothing was removed for evidence purposes or who required replacement clothing for other reasons were supplied with t-shirts and tracksuits. Any used clothing was disposed of. Neither suite had supplies of underwear. Custody sergeants at Acton said detainees could arrange for family or friends to bring in replacement clothing, but the custody sergeant at Southall said this was not possible because there were insufficient staff to search items brought in.

Catering

- 4.27 Detainees were asked about dietary requirements on arrival and three meals a day were provided by the staff canteens. Vegetarian and vegan diets were catered for, but there was no guarantee that the meat was halal or free from cross-contamination with non-halal products. Meals were substantial, but detainees were not usually offered a choice beyond a meat or vegetarian option. Meals were brought from the canteen in Styrofoam containers, but food temperatures were not taken at the point of service and some meals were barely warm by the time they reached detainees. Gaolers said they sometimes reheated meals in the microwave.
- 4.28 Outside recognised meal times, detainees were offered microwave meals. The size of these meals was small and gaolers at Acton said they frequently offered detainees two at the same time. The kitchen areas in both suites were clean and tidy. At Acton, there were clear instructions next to the microwave on how to heat the microwave meals. There were no instructions at Southall so staff relied on the package instructions. Acton had a good supply of different meals catering for a range of dietary and religious needs, but Southall had only three options available, none of which was halal.
- 4.29 By arrangement, the society for the welfare of Jewish prisoners supplied Kosher food to any Orthodox Jewish detainee. Information on this service was available in both suites, but the gaoler at Southall was unaware of it.
- 4.30 Detainees were offered a hot drink or water with their meals and regularly throughout the day.

Activities

- 4.31 Neither suite had an exercise yard. Detainees at Acton were sometimes taken to the small caged area at the emergency exit for fresh air depending on how busy the suite was and the availability of staff as detainees had to be supervised at all times. In our survey, only one detainee said they had been offered outside exercise.
- 4.32 Southall had no books or magazines and Acton had only a few paperbacks. We did not see any detainee being offered a book, but staff sometimes offered detainees their newspapers. In our survey, only one detainee said they had been offered something to read.

- 4.33 Staff said detainees could not have visitors.

Recommendations

- 4.34 Detainees should be offered appropriate privacy when making or receiving a telephone call at the front desk.
- 4.35 A contract should be established with a specialist telephone interpreting service.
- 4.36 Adapted cells should be available for use by detainees with a disability.
- 4.37 Detainees at risk of self-harm should not routinely have their clothing removed, but only as a result of a thorough risk assessment.
- 4.38 The reasons why detainees reported feeling unsafe in custody in Ealing should be assessed by managers and any appropriate remedial action taken.
- 4.39 Use of force incidents should be recorded and formally monitored to comply with ACPO policy. Monitoring should be by nationality, gender, age, disability, religion, sexual orientation, location and the officer involved so that any patterns are identified and action taken where necessary.
- 4.40 Clear guidance and training should be given to custody staff about the particular circumstances when use and type of force and restraints are appropriate, including for particular groups such as juveniles and women. This should include how to defuse situations.
- 4.41 There should be a clear, force-wide policy on the use of incapacitants and Tasers, which makes clear the risks of deployment in confined spaces and precludes their deployment in custody unless all necessary health and safety implications have been thoroughly addressed.
- 4.42 Handcuffs and other restraints should be removed as soon as a detainee is presented to the custody officer unless there is a documented need for their use.
- 4.43 A record should be kept of all use of control and restraint equipment.
- 4.44 Fire training should be given to all custody staff and fire evacuation drills practised regularly. A notice setting out the actions to take in the event of a fire or evacuation should be posted in custody suites.
- 4.45 Call bells should not be muted without clearly documented reasons and only in cases of repeated abuse. In each case, the custody sergeant should assess the risk and document their conclusions.
- 4.46 The use of cell bells should routinely be explained to detainees.
- 4.47 PC gaolers should undertake regular checks of the safety hatches.
- 4.48 On an individually assessed basis, nicotine replacement should be available to smokers.

- 4.49 The availability of additional toilet paper and access to hand washing facilities should be explained to all detainees.
- 4.50 Mattresses and pillows in cells should be cleaned between use.
- 4.51 Detainees should be offered a shower, particularly if they are held for 24 hours.
- 4.52 Towels should be provided to detainees who want to take a shower.
- 4.53 Shower cubicles should be appropriately screened.
- 4.54 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees.
- 4.55 Detainees should be placed in paper evidence suits only if it is necessary to preserve evidence and all other detainees whose clothing is removed or requires replacing should be given replacement clothing.
- 4.56 Meals from the staff canteen should be served at the correct temperature.
- 4.57 Staff should be made aware of the availability of specialist meals for detainees that meet dietary or religious needs.
- 4.58 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air.
- 4.59 Visits should be allowed for those detained more than 24 hours and for young people.
- 4.60 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.

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 Detainees could have someone told of their whereabouts and were given access to legal representation, but telephone calls could not be made in private. Access to appropriate adults and interpreting services was variable. There were also concerns about young people's access to an appropriate adult for matters other than PACE interviews. PACE codes were largely adhered to during interviews, but there was poor record keeping and a number of custody records were incomplete. Detainees were not told how to make a complaint and could not do so while in custody.

Rights relating to detention

- 5.2 Custody sergeants checked the grounds for arrest and detention with the arresting officer and cited examples where they had refused to accept detainees because these were not established or clear. At Acton, there was regular contact with UKBA and the two permanent custody officers also acted as immigration liaison officers. They reported constantly having to chase UKBA to collect immigration detainees. A number of custody records were incomplete and showed no record of release, making it difficult to determine the length of detention.
- 5.3 Acton custody suite was occasionally used as a place of safety for children and young people under section 46 of the Children Act. The young person was kept in the interview room rather than a cell and officers made every effort to hand them over to social services as soon as possible, but this was considerably delayed if they were outside the local social services area. The Southall custody suite was not used as a place of safety for children and young people.
- 5.4 Detainees were asked on arrival if they wanted someone told of their whereabouts. Staff at both suites tried in almost every case to let a detainee tell someone where they were, but calls were made in a public area and afforded little privacy. Exceptionally, detainees were denied use of the telephone following a risk assessment and this had to be authorised by a police inspector.
- 5.5 Detainees were generally told about their rights and entitlements without an interpreter, although this information was given again if an interpreter subsequently attended for an interview (see also paragraph 4.3). Copies of this information were available in the most common languages, but the extent of their use was variable. There were no prompt sheets to help detainees identify their spoken language to the custody sergeant. No rights information was available in large print. Staff at Southall said they usually used other officers to interpret, but would ring interpreters if necessary. There was a list of sign language interpreters, but no evidence that they were used.
- 5.6 Detainees being booked in were regularly asked about any dependency obligations and the custody officer spoke to the person concerned by telephone first before passing it to the detainee. Custody records contained further examples where dependency obligations were catered for. Bail was considered as an option when no other arrangements could be made.

- 5.7 A recently introduced pre-release risk assessment form gave details of organisations and support groups able to assist particular groups. Use of this was variable and few custody records contained evidence of any pre-release risk management planning.

Rights relating to PACE

- 5.8 A duty solicitor scheme provided free legal advice for detainees. Specialist immigration advice was provided by Criminal Defence Solicitors (CDS). Staff at Acton said the duty solicitor scheme worked quite effectively, with solicitors telephoning back within 10 minutes, although calls took place in a public area. Solicitors attended within a reasonable timescale.
- 5.9 Acton had just one consultation room off the charge area, which was insufficient for the size of the suite and meant interview rooms had to be used for consultations with solicitors. The room had a large window, which afforded little privacy as the detainee and their solicitor were in full view of the charge area. It was also poorly soundproofed. Southall did not have a dedicated consultation room so the two interview rooms were used.
- 5.10 Both Acton and Southall used the local authority appropriate adult scheme. Although this offered a 24-hour service, there were some significant delays in the arrival of an appropriate adult following a request. Some custody records also did not record the attendance of an appropriate adult even though one had been requested. Staff at Southall said appropriate adults were used for juveniles, but only for specific actions such as interviews and not for general support.
- 5.11 Solicitors we met were positive about the treatment of detainees and their own treatment by staff. They said PACE was adhered to during interviews. They were given the front sheet of the custody record of the detainee they were representing and could view the detention log on screen. We were told that detainees could receive a copy of their custody record only on request, but that this rarely happened.
- 5.12 Both custody suites had copies of the current PACE code of practice, which were offered to detainees during the booking in process.
- 5.13 Custody records and our observations indicated that detainees were not interviewed while under the influence of alcohol or drugs or medically unfit. Legal representatives we talked to reported that PACE was closely adhered to when considering when to interview detainees. Staff at Southall said they would always call the FME if someone was under the influence of alcohol, while those at Acton said a FME would be called to ascertain fitness for detention and interview if someone had a drink or drug issue and that they would continue only if the FME declared someone fit for interview.
- 5.14 Interviewing officers did not carry out interviews for overly long periods and detainees were given breaks. Custody records showed that detainees were given eight hours rest during 24-hour periods. Legal advisers confirmed that appropriate rest periods were given.
- 5.15 We had no concerns about the management of DNA or forensic samples and all DNA samples were properly submitted to the national DNA database within a suitable timeframe. Forensic exhibits were robustly managed by detective inspectors and sergeants with clear intrusive supervision ensuring good standards were maintained. There were no DNA or forensic samples that were not relevant to ongoing investigations and no issues concerning their storage locally. The evidence fridge at Southall was located at the CID and the DNA fridge at Acton was located in the station and was the responsibility of the two permanent custody

officers. Fridges were clean and well managed. There were no samples over a week old and they were clearly labelled and sealed.

- 5.16 Staff at Acton were required to have detainees booked into the local Ealing magistrates court by noon on weekdays and 10am on Saturdays. This appeared restrictive and meant some detainees were kept in custody longer than necessary, particularly if they had been arrested on a Friday. At Southall, the cut-off time for Ealing magistrates court was 1pm. SERCO transported detainees to court, but officers at Acton would also transport them if necessary. There were no video link facilities at either Acton or Southall.

Rights relating to treatment

- 5.17 In line with other inspections of boroughs in the MPS, complaints from detainees were not taken while they were held in custody. This could have been suppressing the number of complaints and meant that the senior management team had a potentially overly optimistic view of custody performance based on the number of complaints received. Staff said detainees were mainly told they could complain at the front desk when they left custody. One custody record showed repeated requests by a detainee to have a complaint taken from him while in custody. No IPCC complaint forms were visible. Racist complaints were dealt with in the same way as other complaints and no separate monitoring for trends took place.

Recommendations

- 5.18 Custody records should provide an accurate and clear picture of a detainee's experience of custody.
- 5.19 Interview and consultation rooms should be soundproofed and detainees being supported by their legal representatives should not be visible in the charge area.
- 5.20 Managers should ensure that the appropriate adult service in Ealing offers greater flexibility and is available whenever required and not just during interviews.
- 5.21 Detainees aged 17 years should be provided with an appropriate adult.
- 5.22 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.
- 5.23 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.
- 5.24 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.
- 5.25 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on.
- 5.26 The pre-release risk management policy should be implemented consistently, particularly for vulnerable and young people, with actions taken recorded on NSPIS. Custody staff should receive training in this process.

6. Healthcare

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 (FMEs) working to a contract with the Police Authority (with the intention that the services were provided for the commissioner within the Metropolitan Police Forensic Medical Service). They provided a satisfactory service, although there were issues about the timeliness of the service and reports of long delays. In our survey, 44% of detainees rated the overall health service as good or very good. Record keeping was reasonable, although there was no conformity of record keeping or storage of records. There were no mental health liaison services, although those detained under the Mental Health Act (1983) Section 136 were taken direct to hospital accommodation rather than a police station. Services for adults with drug problems were satisfactory, but no service was provided for those with alcohol abuse issues.

Clinical governance

- 6.2 Forensic medical examiner (FME) services were provided under a contract with the Metropolitan Police Forensic Medical Service (FMS). The vast majority of FMEs on the rotas for Acton and Ealing were male and although it was reported that female detainees could ask to see a female doctor, in practice this could not be accommodated. However, there were robust arrangements to ensure that a female chaperone was available on request and this role was seen to be carried out by a female police officer.
- 6.3 Acton, Ealing and Southall police stations served a multicultural population, but written health information was mostly available in English only. Interpreter services were available and used at times, but this was rarely referenced in clinical records and we did not see evidence of this. Interpreters were accessed through a local database. Response times varied greatly and attendance was sometimes delayed until the detainee had been seen by the FME and declared fit to be interviewed. Interpreter services were offered over the telephone or in person, depending on the level of urgency.
- 6.4 The team of drug treatment workers had an office base at Acton. It provided an advisory and assessment service seven days a week. Satisfactory steps were taken to ensure that individual drug health assessments were undertaken confidentially within a safety framework. The staff member we interviewed said they had access to interpreting services and that consultation on both sites took place in a private consultation room.
- 6.5 The contract covering FME services had been updated and signed up to by all FMEs in January 2009. The contract was not easily available to custody staff and no audit or monitoring arrangements were seen to be in place. Staff we spoke to were concerned that the new arrangements had resulted in two separate rota for FMEs because the work area boundaries for the FMEs did not correspond with the basic command unit (BCU) boundaries.
- 6.6 FMEs were expected to cover a large geographical area with a high population density. This regularly impacted on response times, which varied widely from 30 minutes to five hours. Anecdotally, response times also varied between FMEs and according to the time of day. Delays were frequently attributed to the proximity of the changeover period for FME shifts.

Response times were monitored by Forensic Medical Services, rather than locally, and custody staff were unable to clarify the contracted response time expected.

- 6.7 There was a lack of robust clinical governance arrangements. Both custody suites lacked a comprehensive range of healthcare policies and protocols to provide a consistent minimum standard of healthcare delivery. Custody staff were unable to demonstrate any awareness of clinical governance arrangements or lines of accountability for healthcare services. No checks were made by Ealing BCU custody managers to ensure that annual appraisals, clinical supervision or continuous professional development was undertaken. No mandatory training had been provided by FMS for medical staff. FMEs reported that no formal induction or training programmes had been provided at the start of their employment. Training received was restricted to the use of NSPIS, but this had not taken place at the start of their employment. Some of the current FMEs had additional NHS contracted posts that could have enabled them continuously to update their clinical skills. There was no evidence that a training needs analysis had been undertaken to inform the training needs of healthcare professionals engaged in delivering health services to detainees. It was left to individual FMEs to maintain their professional registration and to secure appropriate appraisal, training and development opportunities. However, we were told that a medical director was soon to be appointed and would take on this role among other duties.
- 6.8 Drug advisory workers were given a comprehensive induction and mandatory training programme. There was a monthly supervision framework with sufficient staffing to ensure that this could be delivered as scheduled. Supervision notes were held by the supervisee. No training had been provided by the Constabulary.
- 6.9 Both custody suites had dedicated medical rooms that were rarely used for other purposes. There was no signage on the doors and consultations routinely took place with the door open and in the presence of other officers. There were no curtains around the examination couch in either medical room. The rooms were adequately tidy, but not clinically clean. There was no evidence that an environmental risk assessment had been undertaken and there were small areas of remedial maintenance work required.
- 6.10 Facilities for hand washing, including foam soap dispensers and paper towels, were available in both clinical rooms, as were latex gloves and couch roll. There were no arrangements to conduct regular infection control monitoring or audit. There were arrangements for cleaning the clinical rooms and cleaning schedules were in place, but they were not available to custody staff, who were not aware of minimum cleaning requirements. No infection control policies or protocols were held in the clinical room. Infection control advice was accessed from the local acute NHS trust, but this was reportedly limited to advice on infectious diseases and blood-borne viruses.
- 6.11 None of the sharps boxes were dated or had been signed. The bins were emptied only when full. Clinical waste bags were available and waste was collected regularly from a designated external area by a contractor. Extra collections could be made on request. The service level agreement for clinical waste was not held at the station.
- 6.12 The rooms were poorly equipped. FMEs carried their own examination equipment from station to station as none was available in the FME rooms. There was no inventory or monitoring of the standard of equipment used.
- 6.13 A range of high and low level storage cupboards housing medical supplies were kept locked. A laminated list of stock drugs was available within the cabinets. There were pharmacy waste bins at both sites for the disposal of medication. There were good stock control arrangements

and evidence of regular stock checks. Three named officers were authorised to order medication and one officer was delegated to audit stock. There was evidence of audit.

- 6.14 There had been difficulties with reconciling the stock of controlled drugs and there was evidence of this in the record file. This had been investigated, the cause of missing medication (or recording omission) had been traced and the relevant FMEs advised about their required practice.
- 6.15 We were told that the stock levels at both sites were the same. This caused some problems because drug usage was significantly greater at Acton and maintaining stock levels had therefore been challenging. This has been exacerbated by long delays in the delivery of ordered medicines and there was evidence that some required stock items were absent and of custody staff's repeated efforts to address this. The FMS said stock levels were only a guide to minimum stock to be held and that additions could be made, but this was not known by staff.
- 6.16 A prepared grab bag of medicines was stored in the cabinet at Acton for use should the Ealing custody suite be reinstated in an urgent situation. This bag was clearly labelled and regularly checked and was a good pragmatic solution.
- 6.17 FMEs also carried a range of medications with them to ensure consistent availability to the detainee as required. Instances of FMEs dispensing from their own stock or writing a private prescription to provide stock were reported by FMEs and custody staff. This was poor practice. The doctors' bags that we saw were not lockable.
- 6.18 Following clinical assessment, the FME prescribed and/or dispensed enough medication to cover the expected detention period of the detainee. Medicines were placed in a sealed plastic bag with instructions for administration and recorded in the electronic clinical record (NSPIS). If a detainee arrived with medication in their possession, this was stored with the detainee's property and used only if prescribed by the FME. There were no arrangements to ensure that these medications were securely locked away, contrary to current legislation and national guidance.
- 6.19 There were no medicines management care policies or protocols, British National Formulary or other reference resources available in the clinical examination rooms.
- 6.20 There was no inventory of optimum medical equipment either in the clinical room or in any other area of the custody suites. Some basic dressings and bandages were stored in the clinical rooms. First aid kits in the custody suites were checked and recorded regularly and sealed between checking. Staff said the content of these bags was under review.
- 6.21 Adrenaline was available in the medicine cabinet and face masks for resuscitation were sited in the clinical rooms and general custody suite areas. No oxygen was available at either site. A defibrillator was held in both custody reception areas and readily accessible. These were regularly checked on a daily, weekly and monthly basis. The portable suction unit was primed and ready for immediate use on both sites. All staff interviewed had undertaken appropriate life support training and felt confident to use the defibrillator if required. Training records stated that custody staff had received relevant resuscitation training.

Patient care

- 6.22 Detainees could request to see a healthcare professional at any point in their detention. The custody officer requested brief details to determine the level of urgency. The custody officer

logged a call for the FME and noted on the custody record if a detainee was displaying obvious signs of physical or mental health need. They made and recorded periodic reminder calls to the FME on duty to ascertain an estimated time of arrival. Custody records showed that FME response times varied from 30 minutes to five hours. Detainees in pain or with open wounds were taken immediately to the local accident and emergency department.

- 6.23 If a detainee was found to be receiving a complex regime of medication for a medical condition, custody staff would explore alternative management strategies to custody.
- 6.24 Where detainees disclosed that they were on a drug withdrawal programme and on regular methadone, steps could be taken to access their prescription from the pharmacy, home or through a family member. However, staff said these detainees were usually referred to the FME who would prescribe supportive medication only to cover the period in custody.
- 6.25 A specific cohort of detainees arrested for any one of a list of suspected 'trigger' offences was routinely drug tested by custody staff. A positive drug test meant the detainee was asked if an FME assessment was required and they were automatically referred to the drug advisory worker for assessment. The team of drug treatment workers provided a seven day a week advisory and assessment service and onward referral for further support.
- 6.26 The custody record opened for every detainee on reception included the recording of any health event or assessment. As part of a clinical assessment, the FME made a minimal electronic record containing only those details necessary for custody staff to be aware of to provide safe custody to the detainee. Some FMEs had not received training or clearance to use NSPIS and instead used the traditional Book 83 system to record the outcome of consultations. Copies of these records were retained by custody staff. Custody staff at Acton transcribed the Book 83 information onto the electronic custody record, which was poor practice and risked transcription errors.
- 6.27 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 General Medical Council. FMEs were responsible for their retention and secure storage. Doctors we spoke to had various methods of recording and storing their clinical records. There were no quality monitoring arrangements or steps taken to ensure that these were held securely or if there were processes for safe archiving. The recording of healthcare interventions was therefore inconsistent. It was reported by staff that the quality of clinical records was monitored through dip sampling, but there was no evidence to support this, nor was it carried out by a healthcare professional.
- 6.28 We were concerned to find evidence in one record that the police were aware of the HIV status of a detainee, but with no indication that the detainee had given permission for such confidential information to be shared.
- 6.29 Staff said there were information sharing protocols with all appropriate partner agencies to ensure the efficient sharing of relevant health and social care information. However, these were not easily accessible to custody staff or ourselves.
- 6.30 Detainee consent to intervention or treatment was not recorded. FMEs interviewed said they ensured verbal consent for some procedures, but this practice was not observed.
- 6.31 One doctor we spoke to said he would provide a detainee with a copy of their clinical records, but only after consultation with custody staff.

Substance use

- 6.32 A good person-centred service was provided by the crime reduction initiative team of drug advisory workers. All detainees who had a positive drug test were automatically referred to the drug advisory team and detailed assessments took place. The detainee received a follow up appointment in the community before leaving the station and was given information and advice as appropriate. The drug advisory worker we interviewed reported good networking with partner organisations, including the community mental health team, housing and social services. The team did not provide clean needles or syringes to injecting drug users, but did inform them where these could be obtained.
- 6.33 There were no similar alcohol services, but detainees were signposted to supportive community services and given written information and advice.

Mental health

- 6.34 There was no mental health worker based at the stations, but there were good systems for referring detainees to local NHS mental health teams, supported by established partnership working. Such referrals could be undertaken as a result of FME assessment or by signposting or direct appointments made by drug advisory workers as appropriate.
- 6.35 Custody staff contacted Ealing borough to access approved mental health professionals when sectioning was assessed as appropriate. However, they reported significant delays with waits of up to four hours.
- 6.36 There was evidence of the development of joint protocols with the local mental health trust to facilitate the management of mental health patients who were (or could become) detainees. Examples seen were joint policies and protocols developed to manage Section 136 and abscondment of detained patients.
- 6.37 There was a dedicated Section 136 suite at the mental health department of the local mental health trust. Detainees were taken there straight from the community by police officers. There was a well established patient-centred joint approach to the assessment and treatment framework. Custody staff reported only very occasional use of the custody suite as a place of safety.

Recommendations

- 6.38 Female detainees should be able to see a female doctor on request.
- 6.39 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 There should be clinical governance arrangements that include medicines management and the prevention and control of infection, informed by risk assessment, audit and monitoring systems, with appropriate learning from findings, action planning and timely implementation.
- 6.41 There should be clear lines of accountability and an appraisal system for forensic medical examiners and the contract should be monitored.

- 6.42 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development.
- 6.43 Healthcare professionals should have access to basic clinical equipment, such as a glucometer, sphygmomanometer and ophthalmoscope, in the clinical room.
- 6.44 There should be clear infection control procedures, including cleaning schedules that should be adhered to and monitored.
- 6.45 Clinical examinations should be conducted with due regard for decency, privacy and dignity.
- 6.46 There should be safe pharmaceutical stock management, informed by a review of ordering systems and stock levels to meet demand at individual sites.
- 6.47 Minimum forensic medical examiner response times should be agreed and monitored.
- 6.48 An audit trail for clinical records that includes detainee consent should be established and monitored for quality and completeness.
- 6.49 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance.
- 6.50 Detainees should be able to obtain the results of any clinical examinations.
- 6.51 Injecting drug users being released into the community should be offered clean needles by drugs workers.
- 6.52 Services should be provided to meet the needs of detainees who present with alcohol abuse issues.
- 6.53 There should be a liaison/diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services.

Housekeeping point

- 6.54 Healthcare professionals should have access to up-to-date drug reference books.

7. Summary of recommendations

The following is a list of recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

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 The Metropolitan Police Service should establish a formal mechanism to ensure that boroughs comply with the findings of internal inspection within agreed timelines. (3.17)
- 7.3 The current business model of reporting by exception for Ealing borough should be reviewed to ensure the senior management team has a clearer picture of performance within its custody suites. Custody performance should be a standing agenda item on the performance framework. (3.18)
- 7.4 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. (3.19)
- 7.5 Regular and intrusive dip-sampling of custody records should take place that identifies and addresses poor record-keeping. These checks should be cross-referenced with close-circuit television footage as an additional safeguard. (3.20)
- 7.6 Police officers and staff should access the 'lessons learned' circular from the Independent Police Complaints Commission. (3.21)
- 7.7 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. (3.22)
- 7.8 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. (3.23)

To the Metropolitan Police Authority

- 7.9 The Metropolitan Police Authority should allocate one authority member as lead for custody. (3.24)

Treatment and conditions

- 7.10 Detainees should be offered appropriate privacy when making or receiving a telephone call at the front desk. (4.34)
- 7.11 A contract should be established with a specialist telephone interpreting service. (4.35)
- 7.12 Adapted cells should be available for use by detainees with a disability. (4.36)
- 7.13 Detainees at risk of self-harm should not routinely have their clothing removed, but only as a result of a thorough risk assessment. (4.37)
- 7.14 The reasons why detainees reported feeling unsafe in custody in Ealing should be assessed by managers and any appropriate remedial action taken. (4.38)
- 7.15 Use of force incidents should be recorded and formally monitored to comply with ACPO policy. Monitoring should be by nationality, gender, age, disability, religion, sexual orientation, location and the officer involved so that any patterns are identified and action taken where necessary. (4.39)
- 7.16 Clear guidance and training should be given to custody staff about the particular circumstances when use and type of force and restraints are appropriate, including for particular groups such as juveniles and women. This should include how to defuse situations. (4.40)
- 7.17 There should be a clear, force-wide policy on the use of incapacitants and Tasers, which makes clear the risks of deployment in confined spaces and precludes their deployment in custody unless all necessary health and safety implications have been thoroughly addressed. (4.41)
- 7.18 Handcuffs and other restraints should be removed as soon as a detainee is presented to the custody officer unless there is a documented need for their use. (4.42)
- 7.19 A record should be kept of all use of control and restraint equipment. (4.43)
- 7.20 Fire training should be given to all custody staff and fire evacuation drills practised regularly. A notice setting out the actions to take in the event of a fire or evacuation should be posted in custody suites. (4.44)
- 7.21 Call bells should not be muted without clearly documented reasons and only in cases of repeated abuse. In each case, the custody sergeant should assess the risk and document their conclusions. (4.45)
- 7.22 The use of cell bells should routinely be explained to detainees. (4.46)
- 7.23 PC gaolers should undertake regular checks of the safety hatches. (4.47)
- 7.24 On an individually assessed basis, nicotine replacement should be available to smokers. (4.48)
- 7.25 The availability of additional toilet paper and access to hand washing facilities should be explained to all detainees. (4.49)

- 7.26 Mattresses and pillows in cells should be cleaned between use. (4.50)
- 7.27 Detainees should be offered a shower, particularly if they are held for 24 hours. (4.51)
- 7.28 Towels should be provided to detainees who want to take a shower. (4.52)
- 7.29 Shower cubicles should be appropriately screened. (4.53)
- 7.30 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees. (4.54)
- 7.31 Detainees should be placed in paper evidence suits only if it is necessary to preserve evidence and all other detainees whose clothing is removed or requires replacing should be given replacement clothing. (4.55)
- 7.32 Meals from the staff canteen should be served at the correct temperature. (4.56)
- 7.33 Staff should be made aware of the availability of specialist meals for detainees that meet dietary or religious needs. (4.57)
- 7.34 Detainees held for longer periods or overnight should be offered access to an exercise area in the fresh air. (4.58)
- 7.35 Visits should be allowed for those detained more than 24 hours and for young people. (4.59)
- 7.36 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. (4.60)

Individual rights

- 7.37 Custody records should provide an accurate and clear picture of a detainee's experience of custody. (5.18)
- 7.38 Interview and consultation rooms should be soundproofed and detainees being supported by their legal representatives should not be visible in the charge area. (5.19)
- 7.39 Managers should ensure that the appropriate adult service in Ealing offers greater flexibility and is available whenever required and not just during interviews. (5.20)
- 7.40 Detainees aged 17 years should be provided with an appropriate adult. (5.21)
- 7.41 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. (5.22)
- 7.42 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. (5.23)
- 7.43 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. (5.24)

- 7.44 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.25)
- 7.45 The pre-release risk management policy should be implemented consistently, particularly for vulnerable and young people, with actions taken recorded on NSPIS. Custody staff should receive training in this process. (5.26)

Healthcare

- 7.46 Female detainees should be able to see a female doctor on request. (6.38)
- 7.47 There should be arrangements to support detainees who cannot speak English so that consultations with forensic medical examiners can be conducted in private. (6.39)
- 7.48 There should be clinical governance arrangements that include medicines management and the prevention and control of infection, informed by risk assessment, audit and monitoring systems, with appropriate learning from findings, action planning and timely implementation. (6.40)
- 7.49 There should be clear lines of accountability and an appraisal system for forensic medical examiners and the contract should be monitored. (6.41)
- 7.50 Forensic medical examiners and other healthcare professionals should receive on-going training, supervision and support to maintain their professional registration and development. (6.42)
- 7.51 Healthcare professionals should have access to basic clinical equipment, such as a glucometer, sphygmomanometer and ophthalmoscope, in the clinical room. (6.43)
- 7.52 There should be clear infection control procedures, including cleaning schedules that should be adhered to and monitored. (6.44)
- 7.53 Clinical examinations should be conducted with due regard for decency, privacy and dignity. (6.45)
- 7.54 There should be safe pharmaceutical stock management, informed by a review of ordering systems and stock levels to meet demand at individual sites. (6.46)
- 7.55 Minimum forensic medical examiner response times should be agreed and monitored. (6.47)
- 7.56 An audit trail for clinical records that includes detainee consent should be established and monitored for quality and completeness. (6.48)
- 7.57 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance. (6.49)
- 7.58 Detainees should be able to obtain the results of any clinical examinations. (6.50)
- 7.59 Injecting drug users being released into the community should be offered clean needles by drugs workers. (6.51)

- 7.60 Services should be provided to meet the needs of detainees who present with alcohol abuse issues. (6.52)
- 7.61 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. (6.53)

Housekeeping point

Healthcare

- 7.62 Healthcare professionals should have access to up-to-date drug reference books. (6.54)

Appendix I : Inspection team

Sean Sullivan	-	HMIP team leader
Michael Loughlin	-	HMIP team leader
Paddy Craig	-	HMIC inspector
Anita Saigal	-	HMIP inspector
Lucy Young	-	HMIP inspector
Catherine Nichols	-	HMIP researcher
Elizabeth Tysoe	-	HMIP healthcare inspector
Jan Fookes-Bale	-	CQC inspector

Appendix II : Summary of detainee questionnaires and interviews

Prisoner survey methodology

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

Choosing the sample size

The survey was conducted on 1 July 2009. A list of potential prisoners to have passed through Ealing, Acton or Southall police stations was created, listing all those who had arrived from Ealing Magistrates court within the past month.

Selecting the sample

A total of 54 prisoners were approached. Five prisoners reported either being held in police stations outside Ealing and 10 could speak no English and so it was impossible to determine the police station they had been in. On the day, the questionnaire was offered to 39 prisoners. There were two refusals and seven questionnaires returned blank. All of those sampled had been in custody within the last month.

Completion of the questionnaire was voluntary. One prisoner could not read or write and was therefore 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, 30 (77%) respondents completed and returned their questionnaires.

Police Custody Survey

Section 1: About You

Q2	What police station were you last held at? Acton – 19, Ealing - 2 , Southall – 7, Unknown -- 2	
Q3	What type of detainee were you? Police detainee..... 24 Prison lock-out (i.e. you were in custody in a prison before coming here)..... 1 Immigration detainee 0 I don't know 2	
Q4	How old are you? 16 years or younger 0 40-49 years..... 9 17-21 years 2 50-59 years..... 0 22-29 years 9 60 years or older 0 30-39 years 10	
Q5	Are you: Male..... 30 Female 0 Transgender/Transexual 0	
Q6	What is your ethnic origin? White - British..... 6 White - Irish 0 White - Other 4 Black or Black British - Caribbean 6 Black or Black British - African 4 Black or Black British - Other..... 0 Asian or Asian British - Indian..... 4 Asian or Asian British - Pakistani..... 2 Asian or Asian British - Bangladeshi 0 Asian or Asian British - Other 1 Mixed Race - White and Black Caribbean 3 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..... 5 No 22	
Q8	What, if any, would you classify as your religious group? None..... 2 Church of England 4 Catholic 7	

Protestant	0
Other Christian denomination	5
Buddhist	1
Hindu	1
Jewish	1
Muslim.....	5
Sikh	4
Any other religion, please specify	

Q9	How would you describe your sexual orientation?	
	Straight / Heterosexual.....	28
	Gay / Lesbian / Homosexual	0
	Bisexual.....	0
	Other (please specify):	
Q10	Do you consider yourself to have a disability?	
	Yes.....	7
	No	19
	Don't know	2
Q11	Have you ever been held in police custody before?	
	Yes.....	23
	No	6

Section 2: Your experience of this custody suite

Q12	How long were you held at the police station?	
	1 hour or less	0
	More than 1 hour, but less than 6 hours.....	1
	More than 6 hours, but less than 12 hours.....	2
	More than 12 hours, but less than 24 hours	6
	More than 24 hours, but less than 48 hours (2 days)	13
	More than 48 hours (2 days), but less than 72 hours (3 days).....	4
	72 hours (3 days) or more	4
Q13	Were you given information about your arrest and your entitlements when you arrived there?	
	Yes.....	18
	No	7
	Don't know/Can't remember	3
Q14	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?	
	Yes.....	13
	No	12
	I don't know what this is/I don't remember	3
Q15	If your clothes were taken away, were you offered different clothing to wear?	
	My clothes were not taken	16
	I was offered a tracksuit to wear.....	7
	I was offered an evidence suit to wear.....	2
	I was offered a blanket.....	1

Q16	Could you use a toilet when you needed to?			
	Yes		27	
	No		2	
	Don't Know		0	
Q17	If you have used the toilet there, were these things provided?			
		Yes	No	
	Toilet paper	14	13	
Q18	Did you share a cell at the police station?			
	Yes		3	
	No		26	
Q19	How would you rate the condition of your cell:			
		Good	Neither	Bad
	Cleanliness	9	8	10
	Ventilation / Air Quality	3	9	12
	Temperature	5	6	12
	Lighting	12	5	5
Q20	Was there any graffiti in your cell when you arrived?			
	Yes		14	
	No		11	
Q21	Did staff explain to you the correct use of the cell bell?			
	Yes		6	
	No		22	
Q22	Were you held overnight?			
	Yes		25	
	No		2	
Q23	If you were held overnight, which items of clean bedding were you given?			
	<i>Not held overnight</i>		2	
	<i>Pillow</i>		5	
	<i>Blanket</i>		11	
	<i>Nothing</i>		13	
Q24	Were you offered a shower at the police station?			
	Yes		0	
	No		28	
Q25	Were you offered any period of outside exercise whilst there?			
	Yes		1	
	No		27	
Q26	Were you offered anything to:			
		Yes	No	
	Eat?	23	4	
	Drink?	22	4	

Q27	Was the food/drink you received suitable for your dietary requirements?			
	<i>I did not have any food or drink</i>		3	
	Yes.....		9	
	No.....		15	
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?			
	<i>I do not smoke</i>		9	
	<i>I was allowed to smoke</i>		6	
	<i>I was not offered anything to cope with not smoking</i>		19	
	<i>I was offered nicotine gum</i>		2	
	<i>I was offered nicotine patches</i>		2	
	<i>I was offered nicotine lozenges</i>		0	
Q29	Were you offered anything to read?			
	Yes.....		1	
	No.....		28	
Q30	Was someone informed of your arrest?			
	Yes.....		9	
	No.....		16	
	<i>I don't know</i>		1	
	<i>I didn't want to inform anyone</i>		2	
Q31	Were you offered a free telephone call?			
	Yes.....		18	
	No.....		11	
Q32	If you were denied a free phone call, was a reason for this offered?			
	<i>My phone call was not denied</i>		18	
	Yes.....		1	
	No.....		8	
Q33	Did you have any concerns about the following, whilst you were in police custody:			
		Yes	No	
	Who was taking care of your children	3	15	
	Contacting your partner, relative or friend	12	11	
	Contacting your employer	3	14	
	Where you were going once released	6	11	
Q34	Were you interviewed by police officials about your case?			
	Yes.....		24	
	No.....	5	If No, go to Q35	
Q35	Were any of the following people present when you were interviewed?			
		Yes	No	Not needed
	Solicitor	21	1	0
	Appropriate Adult	2	4	3
	Interpreter	2	4	3

Q36	How long did you have to wait for your solicitor?	
	<i>I did not requested a solicitor</i>	5
	<i>2 hours or less</i>	7
	<i>Over 2 hours but less than 4 hours</i>	4
	<i>4 hours or more</i>	13
Q37	Were you officially charged?	
	<i>Yes</i>	25
	<i>No</i>	4
	<i>Don't Know</i>	0
Q38	How long were you in police custody <u>after</u> being charged?	
	<i>I have not been charged yet</i>	4
	<i>1 hour or less</i>	0
	<i>More than 1 hour, but less than 6 hours</i>	3
	<i>More than 6 hours, but less than 12 hours</i>	6
	<i>12 hours or more</i>	16

Section 3: Safety

Q40	Did you feel safe there?	
	<i>Yes</i>	11
	<i>No</i>	16
Q41	Had another detainee or a member of staff victimised (insulted or assaulted) you there?	
	<i>Yes</i>	16
	<i>No</i>	8
Q42	If you have felt victimised, what did the incident involve? (Please tick all that apply)	
	<i>I have not been victimised</i>	8
	<i>Because of your crime</i>	7
	<i>Insulting remarks (about you, your family or friends)</i>	10
	<i>Because of your sexuality</i>	1
	<i>Physical abuse (being hit, kicked or assaulted)</i>	3
	<i>Because you have a disability</i>	2
	<i>Sexual abuse</i>	0
	<i>Because of your religion/religious beliefs</i>	3
	<i>Your race or ethnic origin</i>	3
	<i>Because you are from a different part of the country than others</i>	2
	<i>Drugs</i>	4
Q43	Were you handcuffed or restrained whilst in the police custody suite?	
	<i>Yes</i>	11
	<i>No</i>	15
Q44	Were you injured whilst in police custody, in a way that you feel was not your fault?	
	<i>Yes</i>	8
	<i>No</i>	18
Q45	Were you told how to make a complaint about your treatment here, if you needed to?	
	<i>Yes</i>	2
	<i>No</i>	23

Section 4: Healthcare

Q47	When you were in police custody were you on any medication?						
	Yes.....					11	
	No.....					15	
Q48	Were you able to continue taking your medication whilst there?						
	Not taking medication.....					15	
	Yes.....					5	
	No.....					6	
Q49	Did someone explain your entitlements to see a healthcare professional, if you needed to?						
	Yes.....					10	
	No.....					13	
	Don't know.....					3	
Q50	Were you seen by the following healthcare professionals during your time there?						
		Yes			No		
	Doctor	15			11		
	Nurse	0			16		
	Paramedic	0			17		
	Psychiatrist	0			16		
Q51	Were you able to see a healthcare professional of your own gender?						
	Yes.....					11	
	No.....					12	
	Don't know.....					3	
Q52	Did you have any drug or alcohol problems?						
	Yes.....					18	
	No.....					9	
Q53	Did you see, or were offered the chance to see a drug or alcohol support worker?						
	I didn't have any drug/alcohol problems.....					9	
	Yes.....					6	
	No.....					11	
Q54	Were you offered relief or medication for your immediate symptoms?						
	I didn't have any drug/alcohol problems.....					9	
	Yes.....					9	
	No.....					9	
Q55	Please rate the quality of your healthcare whilst in police custody:						
		I was not seen by health-care	Very Good	Good	Neither	Bad	Very Bad
	Quality of Healthcare	11	2	5	4	2	3
Q56	Did you have any specific <u>physical</u> healthcare needs?						
	No.....					13	
	Yes.....					8	
	<i>Please specify:</i>					Heart condition, high blood pressure, diabetes	

Q57	Did you have any specific <u>mental</u> healthcare needs?	
	No	17
	Yes	5
	<i>Please specify:</i>	Depression, psychosis



Prisoner Survey Responses for Ealing 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

		Ealing	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		30	349
SECTION 1: General Information			
2	Are you a Police detainee?	89%	86%
3	Are you under 21 years of age?	6%	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%	37%
6	Are you a foreign national?	18%	17%
7	Are you Muslim?	16%	12%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	26%	17%
10	Have you been in police custody before?	79%	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?	64%	73%
13	Were you told about PACE?	47%	54%
14	If your clothes were taken away, were you given a tracksuit to wear?	71%	41%
15	Could you use a toilet when you needed to?	94%	88%
16	If you did use the toilet, was toilet paper provided?	51%	56%
17	Did you share a cell at the station?	10%	4%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	33%	25%
18b	Ventilation/air quality?	13%	18%
18c	Temperature?	21%	12%
18d	Lighting?	54%	43%
19	Was there any graffiti in your cell when you arrived?	56%	59%
20	Did staff explain the correct use of the cell bell?	21%	22%
21	Were you held overnight?	93%	89%
22	If you were held overnight, were you given no clean items of bedding?	49%	33%
23	Were you offered a shower?	0%	8%

Key to tables

	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	Ealing	Police custody comparator
24	Were you offered a period of outside exercise?	4%	6%

Key to tables

	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	Ealing	Police custody comparator
25a	Were you offered anything to eat?	84%	76%
25b	Were you offered anything to drink?	84%	80%
26	Was the food/drink you received suitable for your dietary requirements?	38%	39%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	65%	77%
28	Were you offered anything to read?	4%	13%
29	Was someone informed of your arrest?	32%	43%
30	Were you offered a free telephone call?	63%	50%
31	If you were denied a free call, was a reason given?	13%	21%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	17%	21%
32b	Contacting your partner, relative or friend?	53%	56%
32c	Contacting your employer?	18%	25%
32d	Where you were going once released?	36%	37%
34	If you were interviewed were the following people present:		
34a	Solicitor	95%	74%
34b	Appropriate adult	20%	5%
34c	Interpreter	20%	9%
35	Did you wait over 4 hours for your solicitor?	55%	65%
37	Were you held 12 hours or more in custody after being charged?	64%	65%
SECTION 3: Safety			
39	Did you feel unsafe?	60%	39%
40	Has another detainee or a member of staff victimised you?	68%	43%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	43%	27%
41b	Physical abuse (being hit, kicked or assaulted)	13%	16%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	13%	6%
41e	Drugs	18%	17%
41f	Because of your crime	30%	21%
41g	Because of your sexuality	5%	0%
41h	Because you have a disability	8%	3%
41i	Because of your religion/religious beliefs	13%	4%
41j	Because you are from a different part of the country than others	8%	5%
42	Were you handcuffed or restrained whilst in the police custody suite?	42%	48%

Key to tables

	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	Ealing	Police custody comparator
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	30%	29%

Key to tables

	Any percent highlighted in green is significantly better	Ealing	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		
44	Were you told how to make a complaint about your treatment?	7%	13%
SECTION 4: Healthcare			
46	Were you on any medication?	42%	44%
47	For those who were on medication: were you able to continue taking your medication?	44%	39%
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	39%	36%
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	58%	50%
49b	Nurse	0%	17%
49c	Paramedic	0%	2%
49d	Psychiatrist	0%	3%
50	Were you able to see a healthcare professional of your own gender?	42%	28%
51	Did you have any drug or alcohol problems?	67%	56%
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?	36%	41%
53	Were you offered relief medication for your immediate symptoms?	50%	32%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	44%	29%
55	Do you have any specific physical healthcare needs?	37%	35%
56	Do you have any specific mental healthcare needs?	22%	24%