



Report on an inspection visit to police custody suites in Wandsworth Borough Operational Command Unit

15–18 March 2010

by

HM Inspectorate of Prisons and

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1. Introduction

This report is one in a series relating to inspections of police custody carried out jointly by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice inspectorates. They also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.¹ The inspections look at force-wide strategies, treatment and conditions, individual rights and health care.

This inspection was of the two main custody suites in the London Borough of Wandsworth, within the Metropolitan Police Service. A third, less used, custody suite was also visited.

Strategic oversight of custody, throughout the Metropolitan Police Service, is carried out centrally by the TP Emerald Custody Directorate, with a view to ensuring consistent practice. There were appropriate relationships with the active independent custody visitor scheme and links to the police authority, though there was no custody lead within the authority. There was some good partnership work, particularly – and importantly – with local mental health services.

There were two principal general concerns. One was the state of some of the facilities, where refurbishment plans appeared to be facing further delays. The other was the use, training and oversight of the temporary police constable gaolers who supplemented the work of designated and trained detention officers. This raised issues of consistency in custodial care.

Observed relationships between staff and detainees were professional and relaxed, and risk assessments were generally good. However, there were no special arrangements to deal with the specific vulnerabilities of women and juveniles, and considerable confusion about complaints arrangements. Privacy at the booking-in desks could not be ensured. Information about use of force was not collated at borough level to allow patterns and trends to be monitored.

The requirements of the Police and Criminal Evidence Act (PACE) were adhered to, and staff were clear that police custody would not be used as a place of safety for children and young people under the Children Act. Appropriate adult provision was, however, insufficiently reliable or independent, and we found children being held for lengthy periods without such support. In keeping with national practice under PACE provisions, 17 year olds were excluded from automatic entitlement to the appropriate adult service – a situation that continues to cause us serious concern. For non-English speakers in general, interpretation was not always used when needed, and this was of some concern given the nature of the population.

As we often find, the arrangements for monitoring and governance of the health care contract were weak, and the inspection identified some deficiencies in medicines management and locum doctors' access to information systems. Mental health services, however, were good, as was provision for those with drug and alcohol problems.

In general, this is a positive report. It does, however, raise some systemic issues about the staffing of custody suites, the support available for vulnerable detainees, and the oversight of health services. We hope that its recommendations will be helpful to the Metropolitan Police

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

Service and the borough commander in continuing to improve custodial conditions and treatment in Wandsworth.

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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 Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*² 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 PACE 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. The remaining 52 custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.
- 2.3 This announced inspection was conducted at Wandsworth and Battersea, which are the primary custody suites in the London Borough of Wandsworth. Custody facilities at Tooting police station were also visited. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites.
- 2.4 A survey of prisoners at HMP Wandsworth who had formerly been detained at custody suites in the borough was conducted by an HM Inspectorate of Prisons researcher and inspector to obtain additional evidence (see Appendix II).
- 2.5 Wandsworth had 11 cells and Battersea had 10. They were open 24 hours a day and held adults and juveniles. Tooting had five cells and was opened only for specific police operations or to provide additional capacity when one of the primary suites was closed. The suites had received 7,893 detainees in 2009 and 1,964 detainees in the year to the inspection (998 at Wandsworth, 904 at Battersea and 62 at Tooting).

Strategic overview

- 2.6 The MPS custody directorate within the TP Emerald Custody Directorate had strategic oversight of custody in all boroughs in London. Standard operating procedures (SOPs) were issued to boroughs and aimed to assist in the delivery of a consistent level of service in custody. The Metropolitan Police Authority (MPA) had responsibility for the custody estate, and the official who managed the independent custody visitors (ICV) scheme also had lead responsibility for reporting on custody matters to the MPA, although there was no authority member with a lead for custody. There was an active local ICV scheme, to which the borough was responsive.
- 2.7 The custody estate in Wandsworth borough was old and in need of refurbishment or replacement. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs. Responsibility and accountability for custody in Wandsworth therefore rested with the borough commander, who was a chief superintendent.

² <http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm>

There was a clear management structure overseeing custody in the borough but no formal meetings to discuss relevant issues, which resulted in a disconnection between day-to-day service delivery and senior management oversight. Custody managers carried out regular dip sampling of custody records but some physical checks needed to be improved.

- 2.8 There was a mixture of permanent and temporary custody sergeants. Sergeants were supported by a small number of designated detention officers (DDOs), who were permanent custody staff, and police constable (PC) gaolers who were not. There was some confusion among gaolers about the processes and systems in use. Custody sergeants and DDOs attended nationally approved custody training, but PC gaolers did not, and had only minimal training for the role. Permanent staff attended mandatory first-aid and safety refresher training.
- 2.9 Some good partnership work was evident, notably with mental health services and the UK Border Agency.
- 2.10 Independent Police Complaints Commission (IPCC) 'Learning the Lessons' newsletters and other good practice information was circulated to staff. There was no borough-wide collation of use of force to enable trends and patterns to be analysed.

Treatment and conditions

- 2.11 We observed generally relaxed and respectful relationships between staff and detainees, with staff adopting a sensitive and approachable manner. Juveniles and women were generally treated similarly to other detainees, and staff had a limited awareness of how they could be particularly vulnerable in custody. Disabled access at both main suites was limited, and there were no adapted cells or hearing loops. A limited range of materials for observing major faiths was available.
- 2.12 Booking-in desks were of a good height but there was no privacy for detainees being booked into custody. Custody sergeants did not always effectively manage the activities and behaviour of police staff in the area, or the number of people in custody.
- 2.13 Staff completed risk assessments when detainees arrived in custody. These were generally good, although there were inconsistencies in items being taken from detainees. Staff understood the importance of rousing, although not all carried anti-ligature knives. Handovers between shifts relied on staff goodwill to arrive before their shift started.
- 2.14 There was evidence of an approach emphasising de-escalation, even with difficult or aggressive detainees. However, in our survey, ex-detainees in the borough were more likely than comparators to report being handcuffed or restrained while in custody.
- 2.15 The environment was virtually free of graffiti, but the primary custody suites did not have outside exercise yards and there was no shower at Battersea. A small number of ligature points were found in cells.
- 2.16 Showers were rarely offered at Wandsworth. A mattress and pillow were routinely provided but not cleaned between uses. Blankets and toilet paper were provided on request. The use of cell call bells was not explained to detainees, but they were regularly tested. Fire evacuation arrangements were adequate. The food provided was good but reading materials and visits were rarely offered.

Individual rights

- 2.17 Custody sergeants checked that arrest and detention were appropriate. Custody was not used as a formal place of safety for children and young people under section 46 of the Children Act 1989. There was insufficient use of telephone interpreting services. Rights and entitlements information was available in a range of languages. Detainees were offered support if they had dependency obligations. Pre-release risk assessments were carried out but were often cursory.
- 2.18 PACE was adhered to. Defence solicitors reported good working relationships with staff. Appropriate adult (AA) provision lacked resilience and independence from the police. Police adhered to the PACE definition of a child, which meant that 17-year-olds were not routinely provided with an AA. Detainee DNA samples were processed efficiently, although there were some minor issues with collection and storage.
- 2.19 Detainees wanting to make a complaint were often told to do so at the front of the police station on release, which meant that some had little opportunity to have their complaint investigated. There were considerably differing views among staff and managers about how the complaints system worked in custody.

Health care

- 2.20 Governance arrangements for health care were managed centrally by the MPS. Clinical governance arrangements were unclear and there was little ownership of the provision in the borough. There was an absence of robust monitoring and policies to ensure that provision met need, and management arrangements were not systematic. A director of medical and forensic health had recently been appointed to address these issues across London.
- 2.21 The management of clinical rooms was poor and they were not sufficiently clean. There was overstocking of medications, not all medicines were stored securely and working practices in this regard were unsafe. Recording of checks of defibrillators was adequate.
- 2.22 Our custody record analysis indicated that the average wait for a forensic medical examiner (FME) was one hour 22 minutes. Custody staff demonstrated good patient care. Most FMEs, but not locum doctors, had access to the national strategy for police information systems (NSPIS) custody system.
- 2.23 Drug and alcohol services were good, with continuity of care. Needle exchange was not provided on site. There were good links to community provision. Symptomatic relief was provided when needed.
- 2.24 Mental health services were good. There was a strong relationship between the police and providers, supported by a mental health liaison officer, and few section 136 patients were taken into police custody. Mental health awareness training had been provided to staff.

Main recommendations

- 2.25 The borough should urgently review its staffing model, to ensure that a consistently professional service is provided by staff sufficiently trained in custody, including use of the NSPIS custody system.

- 2.26 Booking-in desks should facilitate effective and private communication between staff and detainees, and custody sergeants should make robust efforts to manage traffic in these areas.
- 2.27 Interpreting services should be used appropriately to ensure that all detainees have access to essential information about their detention.
- 2.28 Appropriate adults should be readily available and promptly deployed to support juveniles and vulnerable adults while in custody.
- 2.29 Managers should ensure that all custody staff and health services professionals adhere to the Metropolitan Police Service guidelines for the security, management, administration and disposal of drugs and medicines in custody. The discovery of missing medicines, particularly controlled drugs, should immediately be notified up the chain of command and to the PCT accountable officer.
- 2.30 The use of force in custody should be monitored locally and at a force-wide level.

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 territorial policing commander was the chief officer lead on custody for the Metropolitan Police Service (MPS). The custody directorate had an inspection function for audit and compliance, health and safety and the implementation of Safer Detention and Handling of Persons in Police Custody 2006 (SDHP) guidance. The commander was on the programme board for SDHP and was focused on ensuring that there was an emphasis on 'professionalising custody'. He was also preparing to introduce integrated prosecution teams and 'virtual courts' through video links in the new custody suites.
- 3.2 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.
- 3.3 The MPS's asset management plan, currently stalled as a result of the wider economic situation, had led to a 'rephasing' of the building plans, with priority being focused according to most pressing need. The borough of Wandsworth was challenged by the current capacity and age of its estate, with no realistic prospect of any major improvement or capacity building in the near future. However, there were longer-term plans, which involved having a 35-cell complex at Wandsworth, which would be the single centralised custody suite for the borough.
- 3.4 Maintenance of the custody suites could be carried out when facilities were open, depending on the work required. If the work required was more substantial, the custody suite would be closed and other arrangements made to accommodate detainees. Most ligature points had been carefully filled in, although there were some minor issues with old toilet seats and two cell bells.
- 3.5 All custody sergeants and designated detention officers (DDOs) had received nationally approved custody training, delivered corporately, before being deployed in custody suites. However, the borough also used police constable (PC) gaolers from operational shifts who had not received custody-specific training before their deployment in the custody suites. PCs were effectively left to get on with the tasks at hand. They could not use the national strategy for police information systems (NSPIS) custody system and therefore had problems updating custody records; this raised concerns over the accuracy of record keeping. They were also unclear about their duties and responsibilities, and this increased the risks faced by detainees, staff and the borough. At the time of the inspection, the borough had seven DDOs, with another 24 due to arrive in November 2010, and we were told that this would remove the need for PC gaolers in custody suites.
- 3.6 The custody managers were responsible for both custody suites and had line manager responsibilities for the DDOs, but not for the custody sergeants or PC gaolers, who were posted into custody from operational frontline shifts and were therefore line managed by their relevant shift inspectors. The custody sergeants in the custody suites were not permanent,

with sergeants posted into the roles. Although sergeants were described as permanent or rotational, on some shifts we found rotational sergeants being used without any permanent sergeants. No permanent sergeants were on night duty shifts, which presented issues of ownership and shift management of the custody suites.

- 3.7 There were good local partnerships with the National Health Service and mental health partner agencies. A police inspector with a mental health liaison role was tasked with formalising protocols with the mental health trust (see paragraph 6.12).
- 3.8 The borough commander regularly attended Local Criminal Justice Board (LCJB) meetings, which were attended by a number of criminal justice partners. The borough had good relationships with the HM Courts Service and Crown Prosecution Service. The chief crown prosecutor and a detective chief inspector met bi-monthly. Relationships with the UK Border Agency (UKBA) were described as good, with a UKBA officer being based at Battersea police station.
- 3.9 There was no Metropolitan Police Authority (MPA) member lead for custody, but an MPA official managed the independent custody visitors (ICV) scheme and had lead responsibility for reporting on custody issues, which was viewed by all parties as an important independent oversight mechanism. ICVs visited the custody suites regularly and were focused on prisoner welfare. They prepared interim station reports and summary reports for the quarterly ICV panel meetings, which were attended by custody managers. When issues of concern were identified by ICVs, they were picked up by the custody manager, and progress reports were then fed back to the ICVs. ICVs and custody managers reported generally good relationships with each other.
- 3.10 In addition to the borough commander, the senior management team (SMT) had a superintendent of operations and a chief inspector of operations. Previously, the portfolio for custody had rested with the Criminal Investigation Department (CID), but the current borough commander had decided in October 2009 to bring responsibility for custody back under the uniform operations command structure. The SMT lead for custody was the chief inspector operations, and at the time of the inspection he had been in post for only a week. He was the line manager for the two custody managers, who were both uniformed inspectors.
- 3.11 The acting borough commander believed that the borough had a good command structure which was reinforced by oversight mechanisms that allowed custody issues to be highlighted. Members of the SMT were encouraged to visit custody and there was evidence of them doing so. There was no formal meeting structure between the SMT and the custody managers, as a result of which we were presented with differing views of the issues facing custody. The SMT was provided with an information management data quality metrics report, which highlighted areas for improvement with regard to the submission of data on custody records. It was mainly concerned with the technical aspect of inputting data correctly, rather than providing a management information picture of custody performance. The MPS could not provide us with management information from the NSPIS custody system. This meant that individual boroughs could not access relevant and timely management information which would assist with strategic planning and staffing models, as well as inform performance around investigative decisions.
- 3.12 The business model was one of exception reporting, which relied on a clear picture of custodial issues being presented to the SMT by way of exception reports or by having them brought to its attention by another mechanism, such as the daily management meetings. These meetings enquired into custody issues every day, but this was mainly from the perspective of investigating incidents or crimes and therefore lacked a strategic focus. There was no formal

record of actions or decisions made, and therefore no identifiable audit trail as to who was responsible for custody planning and decision making.

- 3.13 The borough could have two or three inspectors on duty at any one time. One was the duty officer, who dealt with critical incidents, and the others were the custody managers who were responsible for managing the custody suites. The duty officer was also referred to as the PACE inspector and he or she carried out the Police and Criminal Evidence (PACE) reviews of detainee detentions and ensured that prisoners were dealt with appropriately at all times.
- 3.14 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating adverse incidents. The custody directorate published a 'best of lessons learned' from the Independent Police Complaints Commission (IPCC), and the borough also fed back its own lessons learned from successful interventions with detainees.
- 3.15 Use of force within custody suites was not collated at a local or force-wide level. Officers and staff recorded the use of force against detainees in their custody records and police officers recorded it in their evidential pocket notebooks.

Recommendations

- 3.16 **The Metropolitan Police Authority (MPA) should allocate one authority member as lead for custody.**
- 3.17 **The Metropolitan Police Service (MPS) should address force-wide and borough shortcomings in terms of extracting management information from the NSPIS.**
- 3.18 **There should be a formal meeting structure which facilitates senior management team input into custodial matters and which develops a clear audit trail.**

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 Detainees were generally transported in police vehicles, usually a police transportation vehicle, and were then taken into a caged area to the rear of the custody suite. Staff were respectful in their interactions with detainees, often using first names. We saw examples of them dealing with challenging detainees with patience and sensitivity. Female detainees were supposed to be given the opportunity to speak to a member of staff not connected with the case, although an analysis of the custody records indicated that this practice was applied variably.
- 4.2 Detainees with religious needs were provided with prayer mats, Bibles and Qur'ans in English and Arabic as appropriate. We saw a Muslim detainee washing his feet in a sink at Battersea because of the absence of shower facilities there.
- 4.3 There was no disabled access at either custody suite, and there were no adapted cells or hearing loops.
- 4.4 The booking-in desk was of an appropriate height but afforded no privacy when booking in more than one person at a time. There were also a number of officers standing around in the custody area who were not connected to the case, and sometimes large numbers of people who were not wearing identification, and this added to the lack of privacy.
- 4.5 In both custody suites, juveniles were treated largely the same as other detainees, with the exception that under-17-year-olds were usually provided with an appropriate adult (AA). Staff had a limited awareness of the vulnerability of this group in custody. We saw juveniles being held for long periods, with no consideration as to whether social services needed to be involved, and there were delays in the provision of an AA (.see paragraph 5.12) Officers had received training via an e-learning training package, 'Every Child Matters', but had not received any refresher training. Sergeants said that they would always place juveniles on a minimum of 30-minute observations and would try to ensure their release as soon as possible. Although there were detention rooms for juveniles at both custody suites, these differed little from mainstream cells, except that they were located closer to the booking-in desks. We were told that there was a standard operating procedure in relation to the detention of children and young people, but not all sergeants were aware of it.

Safety

- 4.6 There was a standard risk assessment form on the NSPIS custody system, and sergeants routinely consulted the Police National Computer. They made a note of the detainee's responses, as well as their own perceptions. There were no consistent policies and practices for decisions about whether laces and cords in clothing were removed before locating detainees in a cell.
- 4.7 Approximately half the cells at each custody suite had CCTV. The CCTV was recorded onto VHS tapes that were retained for at least seven years. Anti-ligature knives and keys were not

routinely carried by all staff who visited the cells. Custody sergeants received emails about deaths and near-death incidents in custody and some were aware of the IPCC 'Learning the Lessons' bulletins, but this information was not consolidated in one place that could be easily searched. Staff checked cells between uses for unauthorised items and graffiti, and also understood the importance of rousing. Cells were not shared by detainees.

- 4.8 There was a verbal handover by staff in the custody suite, although this sometimes lacked the necessary detail. Most of the shift changes had no built-in handover either for the custody sergeants or the PC gaolers; instead, there was a reliance on the goodwill of staff to start their shift early.
- 4.9 In our survey, 17% of those at Wandsworth, against the 5% comparator (see appendix III), said that they had been victimised because of their race or ethnic origin, but we did not observe any such issues.

Use of force

- 4.10 Leg restraints and handcuffs were available for use. We were told that CS spray had not been used, but staff were trained in how to care for people who had been subjected to it before their arrival in custody. There had been no instances of taser being used in custody and staff told us that any individual who entered the custody suite having been subjected to taser discharge would be taken straight to hospital.
- 4.11 Staff told us that de-escalation techniques were generally employed in the custody suites. Custody sergeants told us that they were generally informed in advance if a violent detainee was being brought in, and that in such a case they would go out to the police transportation vehicle and risk assess the detainee. When violent detainees arrived, the custody suite was cleared and the detainee taken straight to a cell.
- 4.12 Staff underwent personal safety training twice a year. In our survey, 65% of detainees, against the 46% comparator, said that they had been handcuffed or restrained while in custody. We saw a detainee being booked into custody at Battersea who was left in handcuffs for 25 minutes, until he was strip-searched. The detainee, who had previously been verbally abusive towards arresting officers, had been calm and compliant throughout this time and complained of sore wrists.
- 4.13 We were told that, following the use of force, any visible injuries or complaints about injuries were recorded on the custody log and a forensic medical examiner (FME) would be called.

Physical conditions

- 4.14 Wandsworth was the main custody suite in the borough, with nine cells and two detention rooms. Battersea had eight cells and two detention rooms. The custody suites were reasonably well maintained for their age, but were shabby, grubby and in some cases smelly, with poor ventilation.
- 4.15 There were no outside exercise yards at either Wandsworth or Battersea. All of the cells had internal toilets but none had internal hand washing facilities. Cells were cleared out between uses but were not cleaned. The suite was cleaned twice daily on weekdays and once daily at weekends, and we were told that a deep clean took place approximately every three months.

- 4.16 There was a no smoking policy in operation and no nicotine replacement aids were offered. There had been two virtual fire evacuation exercises in the previous few months and there were sufficient handcuffs available to enable detainees to be evacuated. Smoke alarms were tested regularly.
- 4.17 Cell bell use was not routinely explained to detainees and response times were variable, but they were tested between occupations and seemed to be rarely isolated.

Personal comfort and hygiene

- 4.18 Detainees were provided with a mattress and pillow, which were not routinely wiped down between uses and were often grubby. Blankets and toilet paper were provided on request. Hygiene packs for women were not routinely offered. There was a limited range of toiletries, and at Battersea there were only a couple of tampons and no sanitary towels in stock.
- 4.19 Detainees were able to use the toilet in privacy, as the toilet area was blocked out on the CCTV and domed mirror, although they were not advised of this. There was one shower at Wandsworth custody suite, which offered poor privacy, particularly for female detainees, but none at Battersea. Our custody record analysis highlighted examples of detainees being held for over 24 hours without being offered a shower, and in our survey no ex-detainees said that they had been offered a shower, and 74% said that they had been held for over 24 hours.
- 4.20 For detainees whose clothing was taken, there was a good supply of T-shirts and plimsolls but a limited range of jogging bottoms and sweatshirts, and no underwear. In exceptional circumstances, family and friends could bring clothing in for detainees.

Catering

- 4.21 Meals during the working day were provided from the staff canteen seven days a week at Wandsworth and five days a week at Battersea. They were of good quality but were provided at variable times, with lunch being served as late as 3.30pm. At other times, a range of microwaveable meals were available, including halal and vegetarian options. In our survey, 67% of detainees at Wandsworth, against the 44% comparator, said that the food they were given met their dietary requirements.

Activities

- 4.22 Exercise was not provided because there were no outdoor exercise areas.
- 4.23 There was limited reading material available, with no books in an easy read format or in languages other than English, and what was available was not offered to detainees. Visits were rarely, if ever, facilitated.

Recommendations

- 4.24 **There should be clear policies and provisions to meet the needs of female detainees, juveniles and those with disabilities or mobility issues while they are in custody.**
- 4.25 **There should be consistent practice in relation to safety and the retaining of cords and laces.**

- 4.26 Anti-ligature knives and keys should be carried by staff at all times when visiting cells.
- 4.27 An overlap period should be built into all shifts to facilitate an effective handover among staff.
- 4.28 Detainees should not remain in handcuffs any longer than necessary.
- 4.29 Cells should be clean, in a good state of repair and fit for purpose.
- 4.30 Subject to individual needs assessment, nicotine replacement aids should be available to detainees.
- 4.31 Detainees should routinely be given clean mattresses, pillows, a blanket if wanted, and toilet paper and other hygiene items.
- 4.32 Detainees held overnight and those who are dirty should be offered a shower, and shower areas should allow sufficient privacy, particularly for female detainees.
- 4.33 Detainees held for longer periods should be offered outdoor exercise and visits.

Housekeeping points

- 4.34 The purpose of cell call bells should be explained to all detainees.
- 4.35 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees.
- 4.36 Meals should be provided for detainees at recognised meal times.
- 4.37 Those held in custody should be offered a range of suitable reading material.

5. Individual rights

Expected outcomes:

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

Rights relating to detention

- 5.1 We observed custody sergeants taking proper account of the reports from arresting officers to ascertain that detention was lawful and appropriate. There were several examples in the cases we observed which demonstrated considerate and patient attention to the particular needs of detainees to ensure that they understood the reasons why they had been arrested and brought into custody.
- 5.2 Immigration detainees were not held at Battersea, primarily because of the lack of facilities, such as a shower for overnight detention (see section on treatment and conditions). They were therefore taken to Wandsworth, which had a shower. There was a UK Border Agency (UKBA) officer based at Battersea and we were told that there were no delays in establishing contact with the officer following the arrest of an immigration detainee, to ensure speedy progression of the case.
- 5.3 Staff said that there had been no instances in which custody had been used as a place of safety for children and young people under section 46 of the Children Act 1989 and most expressed a view that this would be inappropriate and strongly resisted.
- 5.4 Detainees were asked if they wanted someone informed about their detention, and we saw staff going to considerable efforts in both stations to locate suggested contacts when the details provided by the detainee were vague. Detainees were given a leaflet about their rights and entitlements and in most cases we saw the custody sergeant ask the detainee if he or she was able to read. However, when two detainees said that they could not read, they were simply not provided with a copy of the leaflet. There were no leaflets in an easy read format for detainees with learning difficulties. The leaflet had been translated into a range of different languages but detainees whose command of English was limited were not asked if they had a preference to have the leaflet in their first language.
- 5.5 A face-to-face interpreting service was available, but there was no access to a professional telephone interpreting service to facilitate three-way communication. We were told that an interpreter would be contacted if necessary, but we had concerns that interpreters were not always used appropriately. Custody sergeants carried out the booking-in process for non-English-speaking detainees as best they could, and this sometimes included the use of an internet translation service, which was inappropriate. In addition, telephone contact was used when face-to-face contact was required. During the inspection, a simple reading test was given to a French-speaking detainee and a decision made not to contact an interpreter even though he showed limited understanding of written English. It was clear to us in subsequent conversations with the detainee that he had not understood the more complex elements of what had been said to him.
- 5.6 Detainees were asked if they had any concerns about dependants while they were being held in custody. When such concerns were raised, staff ensured that proper arrangements were made and that the detainee was reassured as far as possible. Free telephone calls were not

routinely offered to all detainees, but requests to make a call were usually granted unless there was a risk of interference with evidence gathering. We saw custody sergeants using their discretion and offering telephone calls to detainees following the initial booking-in process to alleviate their anxiety.

- 5.7 Pre-release risk management planning was limited in scope and there was no evidence on custody records of individual pre-release risk assessments. The process generally comprised issuing a standard leaflet containing a list of support organisations, regardless of the individual needs of detainees. Some managers told us that vulnerable detainees, such as juveniles, would be taken home if there were concerns for their safety at the point of release, but others said that they lacked the resources to provide such a service.

Rights relating to PACE

- 5.8 All detainees were told of their right to consult a legal representative, free of charge, and those who declined were told that they could change their mind at any time. Detainees were often offered the opportunity to speak to a legal adviser by telephone in advance of a visit. However, a number of the custody records we examined did not confirm that detainees had been told of their right to legal advice.
- 5.9 Detainees were told that they could consult the PACE Codes of Practice at all times.
- 5.10 We witnessed solicitors being able to read the electronic custody record of the clients they represented.
- 5.11 Arrangements for the local authority to provide appropriate adults (AAs) for juveniles or other vulnerable detainees did not operate effectively. Long-standing agreements did not ensure that the service was adequate. No aspect of the service was monitored and it lacked formality and governance, although discussions with the local youth offending team (YOT) were in the early stages of development regarding a service for juveniles. An AA was sought only for juveniles under 17 years (unless considered vulnerable for other reasons), in strict accordance with PACE, rather than in accordance with the definition of a child as described in the Children Act 1989.³
- 5.12 In the first instance, parents or carers were contacted to act as an AA for a juvenile, unless they were prevented from doing so because of possible involvement in the case or unsuitability for some other reason. Both custody suites had a list of volunteers who acted as AA for juveniles and vulnerable adults, but in reality staff were mainly reliant on two or three volunteers from the list, which possibly compromised independence. Custody sergeants described particular difficulties in obtaining an AA late in the evening and they frequently resorted to approaching the local Salvation Army to assist them when their regular volunteers were unavailable. During the inspection, we saw one of the regular volunteer AAs carrying out her duties diligently. She told us that she had met a representative from the local YOT some time ago but did not receive ongoing support or supervision from them, and had not received any training for the role.
- 5.13 We had concerns about the welfare of three children detained at Wandsworth during the inspection, aged 13, 14 and 16. They spent a considerable amount of time waiting outside in the yard before being booked in: up to two hours and 35 minutes after arrival. The children

³ Although this met the current requirements of PACE, in all other parts of the criminal justice system, and international treaty obligations, 17-year-olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

were held in custody overnight and did not speak to their parents until the next morning, pending the completion of a search of their family homes. The mothers of two of the children acted as their AA the following day but there were significant delays in calling a volunteer AA in the third case. The 16-year-old was released at midday the following day but the two younger children were interviewed almost 24 hours after their arrest and subsequently refused bail, and were then held for a second night, to be taken to court the following morning. Contact was made with the local authority out-of-hours service, to notify them that these children had been refused bail and therefore been remanded into the care of the local authority. However, no representative from the local authority attended and no accommodation was offered. Custody staff told us that they could not recall an occasion when local authority accommodation had been provided for juveniles in this situation (see recommendation 5.21).

- 5.14 There were no video link facilities at either custody suite, but no problems were reported with court cut-off times being too early. Arrangements to collect detainees held overnight for court were made by the night duty staff, and escort services were provided by Serco and usually arrived promptly at 8.30am.
- 5.15 The management of DNA and forensic samples appeared to be good. Some minor issues were identified, whereby samples and exhibits were not collected as promptly as they should and DNA was stored in fridges rather than freezers. We noted that a guide for PC gaoles instructed them to put the DNA in the fridge.

Rights relating to treatment

- 5.16 Detainees were not routinely told of their right to make a complaint and there were no notices describing complaints procedures on display in the custody suites. There were inconsistencies in understanding and practice in relation to the taking of complaints. The senior management team told us that complaints were taken by the PACE inspectors while detainees were in custody. However, custody managers and staff told us that detainees were often told to make their complaint at the front of the police station when they were released. This was problematic for detainees who were remanded in custody rather than released from police custody, and also meant that the Metropolitan Police Service was not able to explore the underlying reasons for the complaints. There was no separate system for reporting racist complaints, and staff we spoke to believed that racist incidents would be dealt with through the same processes as general complaints.

Recommendations

- 5.17 Detainees whose first language is not English should be offered a copy of their rights and entitlements in their preferred language, and easy read formats should be available for detainees with learning disabilities.
- 5.18 Pre-release management planning should be based on individual risk assessments to ensure that vulnerable detainees are released safely.
- 5.19 Juveniles aged 17 and under should be provided with an appropriate adult.
- 5.20 Negotiations should take place with the local authority at chief officer level to ensure that the statutory duties to provide an appropriate adult service and suitable accommodation for children and young people who are refused bail and remanded into the care of the local authority (PACE section 38(6) and section 21(2) Children Act 1989) are met.

- 5.21 Bail decisions for children should take full account of their welfare needs, as well as the risk to the public.
- 5.22 All DNA samples should be stored in freezers and PACE samples should be submitted to the National DNA Database as soon as is practicable.
- 5.23 Detainees should be told how to make a complaint and they should be facilitated to do so before they leave custody if necessary.

6. Health care

Expected outcomes:

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

Clinical governance

- 6.1 Primary health services for detainees were provided under contract with Forensic Health Services. The service was doctor led, with individual forensic medical examiners (FME) contracted to provide medical support to detainees and police officers. FMEs worked on a six-hour rota; there was evidence that some worked double shifts, but no FME was on call for more than 12 hours. Most doctors were male but there were no reported problems in accessing a female doctor if a female detainee requested to see one. In our survey, 39% of detainees said that they could see a doctor of their own gender, against the comparator of 28%, and 36% said that the overall quality of care was good or very good, against the comparator of 30%.
- 6.2 A new, part-time director of medical and forensic health, with extensive experience as an FME, had just been appointed. The professional oversight of FMEs was unclear but the medical director told us that this subject was her main focus since appointment. There was an absence of robust monitoring and policies to ensure that provision was meeting need, and management arrangements were not systematic.
- 6.3 In the three custody suites we visited in the borough, medical rooms were clinically unacceptable, with kitchen sinks and furniture used to hold drugs and equipment. They were cleaned every day and were generally tidy, but areas such as the computer desk remained very dusty. Hand-washing facilities were reasonable but hand towels were not stored properly. Clinical waste facilities were available in all rooms but were used for general waste as well as clinical waste. Wandsworth and Battersea did not have general rubbish collection facilities and the floors were in need of deep cleaning. In these two suites, the key to the medical room was hung on a hook behind the custody desk and accessible to anyone. During the inspection, we removed the key several times in both suites, without being challenged. There was no log of when the key was used and by whom. The keys to the medicine cabinets were on the same key ring.
- 6.4 The overall management of medicines was haphazard and potentially dangerous, with custody staff being responsible for managing medicines, including controlled drugs, without being trained for this role. In all suites, use of controlled drugs such as diazepam and dihydrocodeine was recorded in a log book. We found a small discrepancy in the amount of diazepam held in Wandsworth, as well as out-of-date prescription-only medicines. There were excessive quantities of stock and controlled medicines in both Wandsworth and Battersea. In Battersea, two cabinets were used for the storage of medicines. There was an agreed stock list of medicines and pharmaceuticals which stated that minimum quantities of pharmacy products should be held in each station. However, there was no regular audit of stock medicines, and in all suites there were medicines held which were not on the stock list.
- 6.5 We saw officers being given the keys to the medical room and medicine cupboards so that they could self-medicate with stock such as paracetamol.

- 6.6 Custody staff had been trained in the use of defibrillators in the previous year and knew where they were kept. Part of the custody suite daily checks included the efficacy of the defibrillator, its pads and the battery. Suction equipment was in place at all suites.

Patient care

- 6.7 Detainees were asked on arrival whether they wanted see a health professional. If they did, custody staff contacted the on-call FME. Response times varied considerably. In our custody record analysis, the longest wait was seven hours 37 minutes and the average was one hour 22 minutes, but typically it was less than an hour. However, it was evident that custody staff had no hesitation in sending a detainee to hospital if there was a need to do so. The custody record for all detainees included any contact they had had with the FME. Sufficient information was recorded on the system to enable officers to manage detainees appropriately.
- 6.8 We did not observe any occasions where FMEs prescribed medicines over the telephone, and staff told us that they would only administer paracetamol under the instructions of the FME. If a detainee was on prescribed medication, staff telephoned the FME, verified with the patient's GP or pharmacy that he or she was on such medication and, if the FME consented, administered the medication as appropriate. A visiting FME prescribing medication for a detainee would check if it was held in stock and, if not, would complete a private prescription and an officer would collect the medication from a local pharmacy.
- 6.9 All suites had NSPIS computer terminals and FMEs, but not locum doctors, recorded relevant consultation information directly onto this system, as well as making their own clinical notes. We were told that FMEs kept detailed clinical notes at their residential addresses. There was no monitoring of this arrangement, so we could not be sure that clinical records were held safely. Staff were unaware of the right for detainees to have a copy of their clinical records.

Substance use

- 6.10 Substance use services were provided by the Wandsworth Drug Project. The team servicing the custody suites comprised five arrest referral workers, who divided their time between the custody suites and the project's base. Detainees with trigger offences were tested for drugs by custody staff and, if positive, were automatically seen and assessed by an arrest referral worker. Our survey indicated that 46% of detainees were offered the help of an arrest referral worker, against the comparator of 42%, although in our custody record analysis only two detainees in our sample encountered a drug or alcohol worker during their time in custody. One detainee said that, despite asking to see an arrest referral worker, he did not see one before release. Arrest referral workers told us that they did a 'sweep' of cells every day to offer support services to detainees. Detainees could also access support independently.
- 6.11 All juvenile detainees with substance use problems were referred to the appropriate YOT. Following release, detainees resident in the local area were referred to the project base, or, if domiciled out of area, arrest referral workers contacted teams local to the detainee to ensure that continuing support was available. Detainees held in custody and receiving prescribed methadone in the community could continue receiving treatment once they had been assessed by the FME and their prescription had been verified. Symptomatic relief was also available but needle exchange was not provided at any of the suites.

Mental health

- 6.12 A joint MPS and South West London and St George's NHS Mental Health Trust mental health protocol had been produced and provided comprehensive guidelines for the management of detainees with mental health needs. The protocol included the management of detainees held under section 136 of the Mental Health Act (MHA). A senior police officer provided the liaison between the police and mental health services. This officer met approved mental health professionals from Wandsworth Council Social Services bi-monthly to monitor progress between the police and mental health services in the community. The system appeared to work well and demonstrated the robust partnership between police and the community.
- 6.13 Some of the FMEs were section 12 MHA-approved doctors and were able to conduct a mental health assessment on detainees in custody suites. Any detainee presenting with mental health symptoms was referred to the FME for initial assessment and, if necessary, an approved mental health professional was called to undertake a further assessment, accompanied by a lead social worker. If necessary, the detainee would be transferred to a local psychiatric hospital for ongoing management.
- 6.14 A dedicated section 136 suite was designated for use by the borough and was used as necessary by police officers. Eight individuals had been taken directly to this suite since November 2009. Only three detainees had been brought into custody under section 136 throughout 2009, and had been transferred out as soon as possible. The management of detainees with mental health issues appeared to be well structured and officers felt supported when dealing with such individuals, including the provision of relevant training.

Recommendations

- 6.15 **Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners.**
- 6.16 **Clear infection control procedures should be introduced and should include cleaning schedules that should be adhered to and monitored.**
- 6.17 **All clinical records should be stored in accordance with the Data Protection Act 1998 and Caldicott guidance.⁴**
- 6.18 **A system should be introduced to ensure that all detainees have access to an arrest referral worker.**
- 6.19 **Injecting drug users released into the community should be offered clean needles and syringes by drug workers.**

Housekeeping points

- 6.20 Clinical and general waste should be kept separate at all times.
- 6.21 Police staff should not use stock medicines to self-medicate.

⁴ The Caldicott review (1997) stipulated principles and working practices for health care providers, to improve the quality, and protect the confidentiality, of service users' information.

Good practice

- 6.22 *The nomination of a senior police officer to manage the policies and protocols relating to the detention of mentally disordered detainees ensured that such individuals were managed efficiently and effectively.*

7. Summary of recommendations

Main recommendations

- 7.1 The borough should urgently review its staffing model, to ensure that a consistently professional service is provided by staff sufficiently trained in custody, including use of the NSPIS custody system. (2.25, see paragraph 3.6)
- 7.2 Booking-in desks should facilitate effective and private communication between staff and detainees, and custody sergeants should make robust efforts to manage traffic in these areas. (2.26, see paragraph 4.4)
- 7.3 Interpreting services should be used appropriately to ensure that all detainees have access to essential information about their detention. (2.27, see paragraph 5.5)
- 7.4 Appropriate adults should be readily available and promptly deployed to support juveniles and vulnerable adults while in custody. (2.28, see paragraph 5.12)
- 7.5 Managers should ensure that all custody staff and health services professionals adhere to the Metropolitan Police Service guidelines for the security, management, administration and disposal of drugs and medicines in custody. The discovery of missing medicines, particularly controlled drugs, should immediately be notified up the chain of command and to the PCT accountable officer. (2.29, see paragraph 6.4)
- 7.6 The use of force in custody should be monitored locally and at a force-wide level. (2.30, see paragraph 3.15)

Recommendations

Strategy

- 7.7 The Metropolitan Police Authority (MPA) should allocate one authority member as lead for custody. (3.16, see paragraph 3.9)
- 7.8 The Metropolitan Police Service (MPS) should address force-wide and borough shortcomings in terms of extracting management information from the NSPIS. (3.17, see paragraph 3.11)
- 7.9 There should be a formal meeting structure which facilitates senior management team input into custodial matters and which develops a clear audit trail. (3.18, see paragraph 3.12)

Treatment and conditions

- 7.10 There should be clear policies and provisions to meet the needs of female detainees, juveniles and those with disabilities or mobility issues while they are in custody. (4.24, see paragraph 4.5)
- 7.11 There should be consistent practice in relation to safety and the retaining of cords and laces. (4.25, see paragraph 4.6)

- 7.12 Anti-ligature knives and keys should be carried by staff at all times when visiting cells. (4.26, see paragraph 4.7)
- 7.13 An overlap period should be built into all shifts to facilitate an effective handover among staff. (4.27, see paragraph 4.8)
- 7.14 Detainees should not remain in handcuffs any longer than necessary. (4.28, see paragraph 4.12)
- 7.15 Cells should be clean, in a good state of repair and fit for purpose. (4.29, see paragraph 4.14)
- 7.16 Subject to individual needs assessment, nicotine replacement aids should be available to detainees. (4.30, see paragraph 4.16)
- 7.17 Detainees should routinely be given clean mattresses, pillows, a blanket if wanted, and toilet paper and other hygiene items. (4.31, see paragraph 4.18)
- 7.18 Detainees held overnight and those who are dirty should be offered a shower, and shower areas should allow sufficient privacy, particularly for female detainees. (4.32, see paragraph 4.19)
- 7.19 Detainees held for longer periods should be offered outdoor exercise and visits. (4.33, see paragraph 4.23)

Individual rights

- 7.20 Detainees whose first language is not English should be offered a copy of their rights and entitlements in their preferred language, and easy read formats should be available for detainees with learning disabilities. (5.17, see paragraph 5.4)
- 7.21 Pre-release management planning should be based on individual risk assessments to ensure that vulnerable detainees are released safely. (5.18, see paragraph 5.7)
- 7.22 Juveniles aged 17 and under should be provided with an appropriate adult. (5.19, see paragraph 5.11)
- 7.23 Negotiations should take place with the local authority at chief officer level to ensure that the statutory duties to provide an appropriate adult service and suitable accommodation for children and young people who are refused bail and remanded into the care of the local authority (PACE section 38(6) and section 21(2) Children Act 1989) are met. (5.20, see paragraph 5.13)
- 7.24 Bail decisions for children should take full account of their welfare needs, as well as the risk to the public. (5.21, see paragraph 5.13)
- 7.25 All DNA samples should be stored in freezers and PACE samples should be submitted to the National DNA Database as soon as is practicable. (5.22, see paragraph 5.15)
- 7.26 Detainees should be told how to make a complaint and they should be facilitated to do so before they leave custody if necessary. (5.23, see paragraph 5.16)

Health care

- 7.27 Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners. (6.15, see paragraph 6.2)
- 7.28 Clear infection control procedures should be introduced and should include cleaning schedules that should be adhered to and monitored. (6.16, see paragraph 6.3)
- 7.29 All clinical records should be stored in accordance with the Data Protection Act 1998 and Caldicott guidance. (6.17, see paragraph 6.9)
- 7.30 A system should be introduced to ensure that all detainees have access to an arrest referral worker. (6.18, see paragraph 6.10)
- 7.31 Injecting drug users released into the community should be offered clean needles and syringes by drug workers. (6.19, see paragraph 6.11)

Housekeeping points

Treatment and conditions

- 7.32 The purpose of cell call bells should be explained to all detainees. (4.34)
- 7.33 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees. (4.35)
- 7.34 Meals should be provided for detainees at recognised meal times. (4.36)
- 7.35 Those held in custody should be offered a range of suitable reading material. (4.37)

Health care

- 7.36 Clinical and general waste should be kept separate at all times. (6.20)
- 7.37 Police staff should not use stock medicines to self-medicate. (6.21)

Good practice

Health care

- 7.38 The nomination of a senior police officer to manage the policies and protocols relating to the detention of mentally disordered detainees ensured that such individuals were managed efficiently and effectively. (6.22)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Fay Deadman	HMIP inspector
Bridget McEvilly	HMIP health care inspector
Sherrelle Parke	HMIP researcher
Paddy Craig	HMIC inspector
Fiona Shearlaw	HMIC inspector

Appendix II: Custody record analysis

Background

As part of the inspection of Wandsworth police custody, a sample of the custody records of detainees held were analysed for the following three random dates: Saturday 19 December, Sunday 14 February and Thursday 4 March. Custody records were held electronically on NSPIC. A total sample of 30 records were analysed from across Wandsworth:

Custody suite	Number of records analysed
Wandsworth	14
Battersea	13
Tooting	3
TOTAL	30

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

Demographic information

- Four of the detainees were female and 26 were male.
- Only one person under the age of 17 was included in the sample.
- There were 12 detainees in our sample with a white British ethnic background, four with a white European background, two of mixed ethnicity and 13 with a black or ethnic minority background, including: nine from a black African or Caribbean background and three from an Asian background. Seven in the sample were foreign nationals, and all seven were given their foreign national rights.
- Three detainees (10%) had been held for over 24 hours. Sixteen (53%) had been in custody overnight, including those that had arrived during the night and were not released until the morning. Eleven (37%) detainees had been held for less than six hours.
- Eleven detainees (37%) were brought into custody intoxicated, but only four of these were seen by a doctor according to the notes in their detainee logs.
- Custody records showed that only one detainee had previously self-harmed. This information was said to be flagged up on a PNC check, and as a risk assessment was unable to be completed immediately, he was put on constant watch.
- In another custody record, a PNC check flagged up a warning about severe mental health issues and described the detainee as being subject to section 136 of the Mental Health Act within the past 12 months. As a result, the detainee was placed in a CCTV-monitored cell for closer observation. Three (10%) of those in our sample had details of mental health problems on their records, and while their cases did not seem severe, none of these asked for or were allocated an appropriate adult.
- Five detainees in our sample were on some form of medication.

- Seven detainees in our sample (23%) came into custody with injuries, and although a doctor was called out for all of these cases, two records were unclear about whether they had actually been seen by a doctor.
- In four custody records, it was noted to be a detainee's first time in custody.

Removal of clothing

Only one detainee had clothing removed from them. He was described as being drunk and aggressive on arrival and had to be carried into a cell. Officers then removed his bottoms because they had a cord in the waistband, and he was given an evidence suit as a replacement.

Young people

There was only one juvenile in our sample, aged 16 years. He was in custody for nine hours 41 minutes. An appropriate adult was present when a strip-search was conducted, and the young person was placed in a CCVT-monitored cell due to his age.

Interpreters

- While seven detainees in our sample were foreign nationals, only two seemed to require an interpreter. In one of these cases, a PCSO acted as a translator for an immigration detainee, and his rights and entitlements were delivered to him through the PCSO.
- In another case, a detainee described as speaking limited English was initially informed of his rights without an interpreter present, but was later read his rights again when the interpreter arrived.
- A foreign national detainee with limited/no English had his rights printed off in his own language and given to him to read. An officer had noted in the detention log that he had had a conversation with the detainee and felt that his English was good, but an interpreter was called and was present during the detainee's interview.

Inspector reviews

Inspector reviews were held in line with requirements, at the expected times, except for the occasional few which happened late, for which operational issues were always given as a justification.

Services

- In 14 cases, detainees were not offered a telephone call, although most had someone informed of where they were. In two cases, detainees asked for a telephone call but were not granted it, as it may have 'interfered' with the police investigation. In four cases, detainees asked if they could have a telephone call and were granted it.
- From detention logs, it seems that eight detainees were not offered the opportunity for legal advice. In all other cases, detainees had several notes on their detention logs that

officers had reminded them of their 'right to free legal advice'. Legal advice was sought by 16 of those in our sample.

- Thirteen (43%) detainees required the attention of a health care professional. The longest wait was for seven hours 37 minutes, as the FME was called out just before midnight and arrived the following morning. In two cases, it was unclear whether the detainee actually got to see a doctor. The average wait for a doctor was one hour and 22 minutes, but this was not an accurate reflection of our sample. Eight of the 11 people who actually saw a doctor waited for less than an hour.
- Only two detainees in our sample met with a drugs or alcohol worker during their time in custody (both had tested positive for drugs), although several were arrested in an intoxicated state and a number tested positive for cocaine and opiates while in custody. One person who asked to see a drug/alcohol worker, did not get to see one before leaving custody.
- Fifteen (50%) of detainees in our sample were offered at least one meal while in custody. The frequency of meals varied widely, however: one detainee had been in custody for 22 hours and had been offered six meals; another had been in custody for just over 24 hours and had only been offered one meal. Another had been in custody for 14 hours and had been offered drink but no meals according to his detention log. There were few incidents of meals being refused.
- None of the detainees in our sample were given outside exercise.
- None of the detainees in our sample were offered a shower, despite six detainees going to court after being held overnight.
- Just one detainee had been provided with reading materials: a magazine.
- No evidence of cell sharing was found.

Additional points of note

- All four females in the sample were of black and minority ethnic background and varied in age from 18 to 52 years.
 - One had asked to see a female police officer and this seemed to be facilitated with ease. They spoke in a private room, where the detainee disclosed her fears about being deported, and this was duly noted on the detention log.
 - Another was also offered the opportunity to speak to a female officer – which she declined.
- Initial risk assessment statements were largely very clear, and contained helpful information, especially regarding health issue and self-harm issues. Those who were under the influence of drugs or alcohol were clearly marked.
- Pre-release risk assessments were often seen on detention logs, but in most cases these were not completed properly and both 'yes' and 'no' responses on the template remained on the record – indicating that neither option had been chosen. This was often quite confusing, and in one case, where the template suggested a detainee be referred to outside drug agencies for help, the information was not filled in, and would have been particularly useful for the detainee, who tested positive for drugs. Often, pre-release risk assessments failed to acknowledge risks identified in the rest of the custody record, for example spousal abuse and mental health issues.

- Rights and entitlements were frequently mentioned in custody logs, but in many cases it was noted that the detainee was not actually told about their rights and entitlements because it was a 'sleep period'. In one case, the detention log stated that a detainee had not been told of his rights, as it was a sleep period, but the following comment on the log stated that the detainee was given a magazine to read – these comments were only 10 minutes apart.
- There were several allegations of lost property from our survey visit, but custody records in the sample were generally good in noting the items of property that people came in with, and these were signed by the detainee. Some records clearly showed that cash and mobile telephones were kept as evidence, but it was unclear whether detainees were always told this on their departure.

Appendix III: 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 Wandsworth, was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The survey was conducted on 8 March 2010. A list of potential respondents to have passed through Wandsworth, Battersea or Tooting police stations was created, listing all those who had arrived from South Western, Wimbledon or Kingston Magistrates court within the past six months.⁵ This happened in conjunction with a survey for Kingston and Merton police boroughs.

Selecting the sample

In total, 90 respondents were approached. Sixteen respondents reported being held either in police stations outside of Kingston, Merton or Wandsworth, or outside of the six-month time limit, and one 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 73 respondents; there were six refusals, four questionnaires returned blank and one non-return. All of those sampled had been in custody within the previous six months. Thirty questionnaires were returned completed from prisoners who had been through the borough of Wandsworth.

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

Methodology

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

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

- to fill out the questionnaire immediately and hand it straight back to a member of the research team;

⁵ Researchers routinely select a sample of prisoners held in police custody suites within the last two months. Where numbers are insufficient to ascertain an adequate sample, the time limit is extended up to six months. The survey analysis continues to provide an indication of perceptions and experiences of those who have been held in these police custody suites over a longer period of time.

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

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 22 police areas since April 2008.

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

Summary

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

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

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

Police custody survey

Section 1: About you

- Q2 What police station were you last held at?**
Battersea – 9; Wandsworth - 21
- Q3 What type of detainee were you?**
- | | |
|--|----------|
| Police detainee..... | 28 (97%) |
| Prison lock-out (i.e. you were in custody in a prison before coming here)..... | 0 (0%) |
| Immigration detainee | 0 (0%) |
| I don't know | 1 (3%) |
- Q4 How old are you?**
- | | | | |
|---------------------------|----------|------------------------|---------|
| 16 years or younger | 0 (0%) | 40-49 years..... | 3 (10%) |
| 17-21 years | 1 (3%) | 50-59 years..... | 1 (3%) |
| 22-29 years | 16 (53%) | 60 years or older..... | 0 (0%) |
| 30-39 years | 9 (30%) | | |
- Q5 Are you:**
- | | |
|-------------------------------|-----------|
| Male..... | 30 (100%) |
| Female | 0 (0%) |
| Transgender/transsexual | 0 (0%) |
- Q6 What is your ethnic origin?**
- | | |
|--|----------|
| White - British..... | 9 (30%) |
| White - Irish | 0 (0%) |
| White - other | 5 (17%) |
| Black or black British - Caribbean..... | 6 (20%) |
| Black or black British - African | 3 (10%) |
| Black or black British - other..... | 0 (0%) |
| Asian or Asian British - Indian..... | 2 (7%) |
| Asian or Asian British - Pakistani..... | 2 (7%) |
| Asian or Asian British - Bangladeshi | 0 (0%) |
| Asian or Asian British - other | 1 (3%) |
| Mixed heritage - white and black Caribbean | 1 (3%) |
| Mixed heritage - white and black African | 1 (3%) |
| Mixed heritage - white and Asian..... | 0 (0%) |
| Mixed heritage - other | 0 (0%) |
| Chinese | 0 (0%) |
| Other ethnic group | 0 (0%) |
| Please specify: | 3 (100%) |
- Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?**
- | | |
|----------|----------|
| Yes..... | 4 (14%) |
| No | 25 (86%) |

Q8	What, if any, would you classify as your religious group?	
	<i>None</i>	2 (7%)
	<i>Church of England</i>	7 (24%)
	<i>Catholic</i>	7 (24%)
	<i>Protestant</i>	0 (0%)
	<i>Other Christian denomination</i>	2 (7%)
	<i>Buddhist</i>	0 (0%)
	<i>Hindu</i>	1 (3%)
	<i>Jewish</i>	0 (0%)
	<i>Muslim</i>	9 (31%)
	<i>Sikh</i>	1 (3%)
	<i>Any other religion, please specify</i>	1 (100%)
Q9	How would you describe your sexual orientation?	
	<i>Straight/heterosexual</i>	29 (97%)
	<i>Gay/lesbian/homosexual</i>	1 (3%)
	<i>Bisexual</i>	0 (0%)
	<i>Other (please specify):</i>	0 (0%)
Q10	Do you consider yourself to have a disability?	
	<i>Yes</i>	5 (17%)
	<i>No</i>	25 (83%)
	<i>Don't know</i>	0 (0%)
Q11	Have you ever been held in police custody before?	
	<i>Yes</i>	24 (83%)
	<i>No</i>	5 (17%)

Section 2: Your experience of this custody suite

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

Q12	How long were you held at the police station?	
	<i>1 hour or less</i>	0 (0%)
	<i>More than 1 hour, but less than 6 hours</i>	3 (10%)
	<i>More than 6 hours, but less than 12 hours</i>	1 (3%)
	<i>More than 12 hours, but less than 24 hours</i>	4 (13%)
	<i>More than 24 hours, but less than 48 hours (2 days)</i>	14 (47%)
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i>	3 (10%)
	<i>72 hours (3 days) or more</i>	5 (17%)
Q13	Were you given information about your arrest and your entitlements when you arrived there?	
	<i>Yes</i>	21 (70%)
	<i>No</i>	8 (27%)
	<i>Don't know/can't remember</i>	1 (3%)

Q14	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?		
	Yes	16 (55%)	
	No	11 (38%)	
	<i>I don't know what this is/I don't remember</i>	2 (7%)	
Q15	If your clothes were taken away, were you offered different clothing to wear?		
	<i>My clothes were not taken</i>	16 (55%)	
	<i>I was offered a tracksuit to wear</i>	6 (21%)	
	<i>I was offered an evidence suit to wear</i>	6 (21%)	
	<i>I was offered a blanket</i>	1 (3%)	
Q16	Could you use a toilet when you needed to?		
	Yes	26 (87%)	
	No	4 (13%)	
	<i>Don't know</i>	0 (0%)	
Q17	If you have used the toilet there, were these things provided?		
		Yes	No
	<i>Toilet paper</i>	14 (48%)	15 (52%)
Q18	Did you share a cell at the police station?		
	Yes	0 (0%)	
	No	29 (100%)	
Q19	How would you rate the condition of your cell:		
		<i>Good</i>	<i>Neither</i>
			<i>Bad</i>
	Cleanliness	7 (24%)	15 (52%)
	Ventilation/air quality	6 (22%)	13 (48%)
	Temperature	3 (10%)	22 (76%)
	Lighting	10 (36%)	11 (39%)
Q20	Was there any graffiti in your cell when you arrived?		
	Yes	13 (46%)	
	No	15 (54%)	
Q21	Did staff explain to you the correct use of the cell bell?		
	Yes	5 (17%)	
	No	24 (83%)	
Q22	Were you held overnight?		
	Yes	28 (93%)	
	No	2 (7%)	
Q23	If you were held overnight, which items of clean bedding were you given?		
	<i>Not held overnight</i>	2 (5%)	
	<i>Pillow</i>	9 (24%)	
	<i>Blanket</i>	16 (43%)	
	<i>Nothing</i>	10 (27%)	
Q24	Were you offered a shower at the police station?		
	Yes	0 (0%)	
	No	30 (100%)	

Q25	Were you offered any period of outside exercise while there?		
	Yes	0	(0%)
	No	30	(100%)
Q26	Were you offered anything to:		
		Yes	No
	Eat?	22 (76%)	7 (24%)
	Drink?	23 (82%)	5 (18%)
Q27	Was the food/drink you received suitable for your dietary requirements?		
	<i>I did not have any food or drink</i>	3	(10%)
	Yes	18	(60%)
	No	9	(30%)
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?		
	<i>I do not smoke</i>	5	(17%)
	<i>I was allowed to smoke</i>	0	(0%)
	<i>I was not offered anything to cope with not smoking</i>	25	(83%)
	<i>I was offered nicotine gum</i>	0	(0%)
	<i>I was offered nicotine patches</i>	0	(0%)
	<i>I was offered nicotine lozenges</i>	0	(0%)
Q29	Were you offered anything to read?		
	Yes	2	(7%)
	No	27	(93%)
Q30	Was someone informed of your arrest?		
	Yes	16	(53%)
	No	11	(37%)
	<i>I don't know</i>	1	(3%)
	<i>I didn't want to inform anyone</i>	2	(7%)
Q31	Were you offered a free telephone call?		
	Yes	18	(60%)
	No	12	(40%)
Q32	If you were denied a free phone call, was a reason for this offered?		
	<i>My phone call was not denied</i>	18	(64%)
	Yes	0	(0%)
	No	10	(36%)
Q33	Did you have any concerns about the following, while you were in police custody?		
		Yes	No
	Who was taking care of your children	5 (22%)	18 (78%)
	Contacting your partner, relative or friend	13 (50%)	13 (50%)
	Contacting your employer	7 (29%)	17 (71%)
	Where you were going once released	5 (21%)	19 (79%)
Q34	Were you interviewed by police officials about your case?		
	Yes	29	(97%)
	No	1	(3%)
			If No, go to Q36

Q35	Were any of the following people present when you were interviewed?		
		Yes	No
			<i>Not needed</i>
	Solicitor	18 (67%)	7 (26%)
	Appropriate adult	2 (11%)	8 (42%)
	Interpreter	0 (0%)	10 (50%)
Q36	How long did you have to wait for your solicitor?		
	<i>I did not requested a solicitor</i>		11 (38%)
	<i>2 hours or less</i>		3 (10%)
	<i>Over 2 hours but less than 4 hours</i>		4 (14%)
	<i>4 hours or more</i>		11 (38%)
Q37	Were you officially charged?		
	Yes		29 (100%)
	No		0 (0%)
	<i>Don't know</i>		0 (0%)
Q38	How long were you in police custody <u>after</u> being charged?		
	<i>I have not been charged yet</i>		0 (0%)
	<i>1 hour or less</i>		1 (3%)
	<i>More than 1 hour, but less than 6 hours</i>		4 (14%)
	<i>More than 6 hours, but less than 12 hours</i>		7 (24%)
	<i>12 hours or more</i>		17 (59%)
Q39	Do you have any other comments about your time in police custody?		
	<u>Wandsworth Police Station:</u>		
	“They were very rude and said they never had any toilet roll and told me to use water.”		
	“They gave me a curry and I cannot eat spicy food; they said tough luck.”		
	“People need to do all they can to change the way the police treat people. I rely on people like you for help because this is not on. There is only so much we will take before we take action. They robbed me of £60 cash; what do I do about this?”		
	“I was only given a chance to clean my mouth before going to court.”		
	“Sometimes it was quite cold, and was not able to have two spoons of sugar in my tea because there was not enough.”		
	“I spent time in a dirty blanket in a cold room, and was given bad food; burnt toast.”		
	“I asked for a translator but the officer said I didn’t need it.”		

Section 3: Safety

Q40	Did you feel safe there?		
	Yes		16 (55%)
	No		13 (45%)

- Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?**
 Yes 13 (45%)
 No 16 (55%)
- Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)**
- | | | | |
|--|----------|---|----------|
| <i>I have not been victimised</i> | 16 (42%) | <i>Because of your crime</i> | 3 (8%) |
| <i>Insulting remarks (about you, your family or friends)</i> | 4 (11%) | <i>Because of your sexuality</i> | 0 (0%) |
| <i>Physical abuse (being hit, kicked or assaulted)</i> | 3 (8%) | <i>Because you have a disability</i> | 0 (0%) |
| <i>Sexual abuse</i> | 0 (0%) | <i>Because of your religion/religious beliefs</i> | 1 (3%) |
| <i>Your race or ethnic origin</i> | 5 (13%) | <i>Because you are from a different part of the country than others</i> | 1 (3%) |
| <i>Drugs</i> | 5 (13%) | | |
| <i>Please describe:</i> | | | 5 (100%) |
- Q43 Were you handcuffed or restrained while in the police custody suite?**
 Yes 19 (66%)
 No 10 (34%)
- Q44 Were you injured while in police custody, in a way that you feel was not your fault?**
 Yes 7 (24%)
 No 22 (76%)
- Q45 Were you told how to make a complaint about your treatment here if you needed to?**
 Yes 1 (3%)
 No 28 (97%)

Q46 Do you have any other comments about safety in the police custody suite?
Wandsworth

“I never felt that I was safe, and I was never offered food, because of the time so they told me.”

“They were very forceful and I came to jail with a big scar on my forehead [as evidence of this].”

“I will never feel safe in custody... It was the worst time in my life; the treatment is very wrong and very unfair.”

“Some officers are very rude, they want to get a reaction.”

Section 4: Health care

- Q47 When you were in police custody were you on any medication?**
 Yes 13 (48%)
 No 14 (52%)
- Q48 Were you able to continue taking your medication while there?**
- | | |
|------------------------------------|----------|
| <i>Not taking medication</i> | 14 (52%) |
| Yes | 4 (15%) |
| No | 9 (33%) |

Q49	Did someone explain your entitlements to see a health care professional if you needed to?						
	Yes					12 (44%)	
	No					15 (56%)	
	Don't know					0 (0%)	
Q50	Were you seen by the following health care professionals during your time there?						
		Yes		No			
	Doctor	17 (63%)		10 (37%)			
	Nurse	1 (5%)		20 (95%)			
	Paramedic	1 (5%)		20 (95%)			
	Psychiatrist	0 (0%)		20 (100%)			
Q51	Were you able to see a health care professional of your own gender?						
	Yes					10 (38%)	
	No					12 (46%)	
	Don't know					4 (15%)	
Q52	Did you have any drug or alcohol problems?						
	Yes					17 (63%)	
	No					10 (37%)	
Q53	Did you see, or were offered the chance to see a drug or alcohol support worker?						
	<i>I didn't have any drug/alcohol problems</i>					10 (37%)	
	Yes					8 (30%)	
	No					9 (33%)	
Q54	Were you offered relief or medication for your immediate symptoms?						
	<i>I didn't have any drug/alcohol problems</i>					10 (37%)	
	Yes					4 (15%)	
	No					13 (48%)	
Q55	Please rate the quality of your health care while in police custody:						
		I was not seen by health care	<i>Very good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>
	Quality of health care	10 (37%)	0 (0%)	6 (22%)	6 (22%)	2 (7%)	3 (11%)
Q56	Did you have any specific <u>physical</u> health care needs?						
	No					19 (68%)	
	Yes					9 (32%)	
	Please specify:					9 (100%)	
Q57	Did you have any specific <u>mental</u> health care needs?						
	No					22 (79%)	
	Yes					6 (21%)	
	Please specify:					7 (100%)	



Prisoner survey responses for Wandsworth Police 2010

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

		Wandsworth Police	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	748
SECTION 1: General information			
2	Are you a police detainee?	96%	88%
3	Are you under 21 years of age?	4%	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)?	54%	31%
6	Are you a foreign national?	14%	13%
7	Are you Muslim?	31%	11%
8	Are you homosexual/gay or bisexual?	4%	2%
9	Do you consider yourself to have a disability?	16%	19%
10	Have you been in police custody before?	83%	91%
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 24 hours?	74%	64%
12	Were you given information about your arrest and entitlements when you arrived?	70%	74%
13	Were you told about PACE?	55%	55%
14	If your clothes were taken away, were you given a tracksuit to wear?	46%	43%
15	Could you use a toilet when you needed to?	86%	90%
16	If you did use the toilet, was toilet paper provided?	48%	53%
17	Did you share a cell at the station?	0%	3%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	25%	32%
18b	Ventilation/air quality?	22%	21%
18c	Temperature?	10%	15%
18d	Lighting?	36%	43%
19	Was there any graffiti in your cell when you arrived?	47%	57%
20	Did staff explain the correct use of the cell bell?	17%	23%
21	Were you held overnight?	94%	91%
22	If you were held overnight, were you given no clean items of bedding?	35%	29%
23	Were you offered a shower?	0%	10%
24	Were you offered a period of outside exercise?	0%	6%
25a	Were you offered anything to eat?	76%	79%
25b	Were you offered anything to drink?	83%	82%
26	Was the food/drink you received suitable for your dietary requirements?	67%	44%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	84%	79%
28	Were you offered anything to read?	6%	15%
29	Was someone informed of your arrest?	54%	43%
30	Were you offered a free telephone call?	60%	50%

Key to tables

		Wardsworth Police	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.		
31	If you were denied a free call, was a reason given?	0%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	21%	14%
32b	Contacting your partner, relative or friend?	50%	52%
32c	Contacting your employer?	30%	19%
32d	Where you were going once released?	20%	32%
34	If you were interviewed were the following people present:		
34a	Solicitor	67%	73%
34b	Appropriate adult	10%	7%
34c	Interpreter	0%	7%
35	Did you wait over four hours for your solicitor?	60%	63%
37	Were you held 12 hours or more in custody after being charged?	58%	63%
SECTION 3: Safety			
39	Did you feel unsafe?	45%	38%
40	Has another detainee or a member of staff victimised you?	45%	42%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	14%	23%
41b	Physical abuse (being hit, kicked or assaulted)	10%	14%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	17%	5%
41e	Drugs	17%	16%
41f	Because of your crime	10%	19%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	0%	3%
41i	Because of your religion/religious beliefs	4%	3%
41j	Because you are from a different part of the country than others	4%	5%
42	Were you handcuffed or restrained whilst in the police custody suite?	65%	46%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	25%	25%
44	Were you told how to make a complaint about your treatment?	4%	14%
SECTION 4: health care			
46	Were you on any medication?	49%	45%
47	For those who were on medication: were you able to continue taking your medication?	32%	39%
48	Did someone explain your entitlement to see a health care professional if you needed to?	44%	35%
49	Were you seen by the following health care professionals during your time in police custody?		
49a	Doctor	62%	48%
49b	Nurse	6%	17%
49c	Paramedic	6%	4%
49d	Psychiatrist	0%	4%
50	Were you able to see a health care professional of your own gender?	39%	28%
51	Did you have any drug or alcohol problems?	62%	55%
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?	46%	42%
53	Were you offered relief medication for your immediate symptoms?	24%	35%
54	For those who had been seen by health care, would you rate the quality as good/very good?	36%	30%
55	Do you have any specific physical health care needs?	32%	34%
56	Do you have any specific mental health care needs?	21%	25%