Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Metropolitan Police Service Borough Operational Command Unit of Southwark

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

19–22 November 2013

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the Glossary of terms on our website at:
http://www.justice.gov.uk/downloads/about/hmipris/Glossary-for-web-rps_.pdf

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

This publication is available for download at: http://www.justice.gov.uk/about/hmi-prisons or http://www.hmic.gov.uk

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

Contents

Contents

Section 1. Introduction

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

This inspection of police custody in Southwark was the second we have carried out; the first was at the very beginning of our joint work programme, in 2008. The format of our reports has altered since that time, although the focus remains on outcomes for detainees. We have referred to recommendations made in our previous report where relevant, taking into account the changes to the custody facilities in Southwark over the past five years.

Strategic oversight of the suites was provided centrally by the Metropolitan Police Service (MPS) Criminal Justice Directorate within the Territorial Policing department, which seeks to ensure consistency in custody provision across all London boroughs. They had recently undertaken their own inspection and it was clear to us that several processes to improve the care of detainees had been introduced as a consequence. Day-to-day management of custody was delegated to the borough operational command unit (BOCU) commander.

Custody was discussed at a range of internal meetings. Staffing of the suite needed to be reviewed to ensure that there were always enough staff to cope with demand. The recent introduction of custody support inspectors across boroughs, in this instance, twinning with Lewisham, had led to some problems with ensuring that their PACE reviews were carried out at the correct time due to the time taken travelling between the suites. The senior leadership team were aware of the issue and were monitoring it to see if improvements could be made. As elsewhere in the MPS, there was a lack of appropriate monitoring of the use of force.

While we saw some excellent interactions between custody sergeants and detainees, we also witnessed some abrupt and curt responses from DDOs. Although the suite had been recently refurbished, which had increased its capacity, some of the cells were extremely cold and we saw detainees with blankets wrapped around them to keep warm. This needed to be addressed quickly. While the suite was generally clean, the exercise yards were filthy and there were too many cells out of action for cleaning or maintenance.

As we have found in a number of recent inspections, both in London and across the country, courts stopped accepting detainees too early in the day. This was something over which the custody staff had no control, but it potentially affected the welfare of detainees. HM Inspectorate of Prisons will investigate this further during their inspection of court custody.

The suite benefitted from having a nurse on site 24 hours a day, with support from a forensic medical examiner. However, there was no mental health liaison and diversion scheme and sometimes there was a considerable wait for a mental health emergency duty team, which had a detrimental effect on the care of detainees with mental health issues. Custody was rarely used as a place of safety under the Mental Health Act.

It was pleasing to note that of the 38 recommendations in our previous report which remain relevant to the custody suite in Southwark, 15 had been achieved and eight had been partially achieved. However, there were some disappointing gaps in achievements which could have been easily implemented, such as allowing detainees to have a small supply of toilet paper in their cell, subject to risk assessment.

This report provides a small number of recommendations to assist the force and the Mayor's Office for Policing and Crime to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

Thomas P Winsor
HM Chief Inspector of Constabulary

Martin Lomas
HM Deputy Chief Inspector of Prisons

May 2014

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the Association of Chief Police Officers (ACPO) *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 This inspection of Metropolitan Police Service (MPS) borough of Southwark was the second we have carried out; the first was in 2008 at the beginning of our joint work programme. The MPS have improved services in custody in the last five years, and we have revised our Expectations. Since our previous inspection the force had rationalised their custody provision and there was now just one suite of 30 cells at Walworth Road, with another suite, of eight cells, for the detention of terrorist suspects only. The suites at Peckham and Southwark were no longer in use.

2.4 We examined the custody strategy, as well as treatment and conditions, individual rights and health care in the custody suites. From 1 April 2013 to 18 November 2013 there had been 5,163 detainees held at the suite.

Strategy

2.5 Strategic leadership for the custody function was provided by the borough operational command unit (BOCU) Commander. In the senior leadership team, a chief inspector led the custody function. Custody was discussed at a range of internal meetings, including a monthly custody management meeting for the custody staff.

2.6 The suite was staffed by permanent custody sergeants, who were managed by a custody manager. There were also permanent DDOs. Staff received training before starting work in custody and had regular refresher training. There were a total of four custody support inspectors, two of whom were based at Lewisham. This arrangement had led to some delays in inspectors reviews, which the borough had identified and was working to resolve. Staff told us that they did not see all of the senior management team in the custody suite, which would have provided management oversight of the care and welfare of detainees.

---

[1] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

2.7 There was a comprehensive territorial policing criminal justice (TPCJ) framework for sampling a selection of the custody records to quality assure the custody process. It was comprehensive and included person escort records and cross referencing to CCTV where appropriate. There was auditable, qualitative feedback to staff. The custody manager had oversight of the system and staff reported successful interventions. Learning points from successful interventions were communicated to staff and they were provided with training when required. There was limited awareness among staff about how to access the TPCJ intranet site, which contained Independent Police Complaint Commission (IPCC) 'learning the lessons' information, policies and operating procedures.

2.8 The borough commander was a member of the local Health and Wellbeing Board, which was pleasing as such attendance is not mandatory. Other strategic partnerships included a joint performance meeting with criminal justice partners and regular meetings with the Director of Children's Services and Youth Offending Services manager. The active independent custody visitors reported no significant issues.

Treatment and conditions

2.9 We saw some good interactions and de-escalation of situations with detainees – some of whom were challenging – by custody staff at the booking in desk. However, some of the DDOs were abrupt during their interactions with detainees. Women detainees were treated respectfully but a useful information leaflet that had been prepared was not always issued. There was limited provision for disabled detainees. A range of religious artefacts were available, but some of the contents were not properly stored. There was no means of determining the direction of Mecca in the cells or cell corridors.

2.10 There was no specific provision for young people, or procedures in place to reduce the length of their detention. Staff had not thought about the best cell in which to place a young person. However, they had received 'Every Child Matters' training and were clear about the care to be provided for young people with safeguarding issues.

2.11 Reasonable privacy at the booking in desks was undermined by the number of non-custody staff moving around the custody suite. There was poor management of the suite, with a lack of control over the number of people present, and non-custody staff taking cell keys and going to speak with detainees.

2.12 Custody staff were competent to assess and manage risks presented by detainees and risk management was proportionate; levels of observation were altered in discussion with the health care professional on site. Constant supervision was well conducted and the rousing system was well used. Staff had personal issue ligature knives but not all carried them, despite a recommendation in our previous report. Some staff handovers about the care of detainees were poor, although handover notes in the custody records were thorough and incoming custody sergeants went from cell to cell introducing themselves.

2.13 Pre-release risk assessments were completed well and we saw some very good assessments conducted using a leaflet that listed various support agencies. Use of force was proportionate and not all detainees were handcuffed. For those that were, cuffs were usually removed at the desk, although there were exceptions. We saw very little strip searching and when it was done, it was proportionate. There was a specific strip search room without CCTV. The use of force in custody was not centrally recorded or monitored.

2.14 Cell call bells sounded clearly and were answered promptly via intercom by a DDO located behind the custody desk. The intercom system allowed external calls to be put through to cells and we observed a number of detainees being permitted a call to a friend or partner. Detainees were not told when or how to use the cell call bell.

2.15 Detainees were not always able to be clean and comfortable while in custody and did not always have access to outdoor exercise. Although towels and clean, private showers with hot water were available, none of the detainees we spoke to were offered a shower. None of the detainees were offered a shower prior to going to court. There were plenty of blankets, which were needed because some of the cells were extremely cold and detainees spending long periods in a cell needed more than one. Detainees had to ask for toilet paper, which was disappointing, given the proportionate risk assessment. Although the image of the toilet area was pixelated on the CCTV, we met detainees who had not been told this.

2.16 Detainees we spoke to were not offered reading material. Stocks of old magazines and books were available, but there was nothing for young people or in other languages. Meals were provided by the canteen in the morning and at lunchtime and microwave meals were available outside of these times. Hot drinks and water were provided throughout the day. Detainees were not offered time in the open air. Visits were permitted, depending on individual circumstances and the availability of space.

Individual rights

2.17 Custody sergeants gave us examples of when they had refused detention if appropriate. Arresting officers were aware of alternatives to custody but we were told that not all acted in accordance with this; some custody sergeants said there was an impetus to improve arrest figures. Senior managers had told them voluntary attendance at the police station, as opposed to arrest (known in the MPS as 'caution plus three') should only be used in exceptional circumstances, which was not a lawful order, nor in the spirit of PACE Code G[2]. There was evidence of reasonable progression of investigations, although staff told us that detainees would be 'bedded down' rather than be interviewed during the night.

2.18 The staff had good links with Home Office immigration enforcement staff who informed them in advance of operations to bring in suspected illegal immigrants. Most stayed no more than 48 hours in the custody suite.

2.19 Family members were preferred as appropriate adults and custody sergeants were satisfied with the appropriate adult service from the local social services and youth offending teams, although they did not work through the night.

2.20 Detainees were told their rights on booking in and there were plenty of posters about obtaining a solicitor on display, including in other languages, but no up-to-date copies of PACE Codes of Practice. PACE reviews were usually undertaken in person, but were often brief. Many were conducted either too early or too late in a person's time in custody.

2.21 Not all detainees were able to appear in court promptly. The latest the local court would take a detainee from police custody was about 1pm during the week and first thing in the morning on Saturdays, which was too early. There was also a virtual, video link court, but

---

[2] Code G of PACE states that: 'The use of the power [of arrest] must be fully justified and officers exercising the power should consider if the necessary objectives can be met by other, less intrusive means. Arrest must never be used simply because it can be used.

the selection criteria for this were unclear. Detainees were provided with a leaflet about the virtual court which set out the advantages of appearing in it, with no mention of possible disadvantages.

2.22 Detainees were not provided with information about how to make a complaint and were not able to do so easily. Those wanting to complain were sent to the front desk unless the custody sergeant could sort out the complaint immediately with the detainee, which meant that not all detainees had an opportunity to complain. There were no IPCC leaflets available.

Health care

2.23 The MPS employed custody nurse practitioners who were based on site at all times and who had access to forensic medical examiners (FMEs) for support if required. The clinical facilities and cleaning standards were good, but some alterations were required to be fully compliant with infection control requirements. The nurses received comprehensive training for the role and had regular managerial supervision and appraisal, but clinical supervision was underdeveloped. Custody staff were all trained in emergency first aid and the available emergency equipment was good. However, there was a lack of equipment to manage an airway, which could reduce the effectiveness of the response.

2.24 Detainees were referred promptly and assessment and risk evaluation by the nurses was effective. We observed good verbal handovers of key issues from and to custody staff. Consultations with detainees were comprehensive, respectful and provided custody staff with appropriate information. Nurses made detailed clinical records on the electronic patient clinical record system and all health professionals made clear instructions on the NSPIS. FMEs kept their own clinical notes.

2.25 Medication management was reasonably good and medications were stored securely, but there were several open boxes of medicines in use and weekly checks were not consistently completed. The storage of heat sensitive medicines was not in line with guidance and presented a risk.

2.26 Discretionary drug testing and requests from custody staff and detainees concerning drug and alcohol problems were responded to promptly by Southwark Drug Intervention Programme (DIP) team, including good out of hours arrangements. The DIP workers made appropriate community referrals with detainee consent.

2.27 Detainees with a mental health issue were assessed by the custody nurse practitioner, who contacted the local mental health team if required. Response times were dependent on access to the emergency duty team and there were often significant delays as a result. The lack of a mental health liaison and diversion scheme slowed the management of detainees with mental health issues and had a negative impact on the care for other detainees. Custody suites were rarely used to detain people held under section 136 of the Mental Health Act[3]. When they were held it was often due to a lack of NHS beds or space in section 136 suites.

---

[3] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

Main recommendations

2.28 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and establish learning for the force.

2.29 The instruction that Code G of PACE should only be used in exceptional circumstances should be immediately withdrawn.

2.30 The Metropolitan Police Service should ensure officers comply with Code G of PACE and develop provisions such as street bail and voluntary attendance.

Section 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 well-being of detainees.

Strategic management

3.1 The Metropolitan Police Service (MPS) had a territorial policing criminal justice (TPCJ) directorate, led by a commander in territorial policing headquarters. A superintendent was responsible for the day-to-day management of the TPCJ. Responsibility for day-to-day management of Southwark's custody suites and delivery of custody services had been devolved to the borough operational command unit (BOCU) commander, who was a chief superintendent.

3.2 The TPCJ had an inspection function for audit and compliance, health and safety and the implementation of the Authorised Professional Practice (APP) on Detention and Custody published by the College of Policing. Policies were signed off at a strategic command level in the MPS, and the TPCJ provided standard operating procedures (SOPs) that supported the delivery of force policies in each MPS custody suite. The SOPs covered a broad spectrum, including use of police custody, use of CCTV and guidance to custody staff on the supervision of detainees. They were designed to help BOCUs deliver a consistent service.

3.3 The borough commander exercised strategic leadership of the custody function for the borough of Southwark. In the senior leadership team (SLT), a chief inspector led the custody function, and managed a custody manager, who was an inspector.

3.4 The TPCJ maintained an organisational risk register for all MPS custody suites. The BOCU commander had responsibility for implementing the local work on risks and introducing measures to mitigate them.

3.5 There was a register of SLT visits to the custody suite to check that risks were being managed. However, it showed, with one exception, that only the chief inspector custody lead was undertaking these visits, despite guidance from the MPS to the contrary.

3.6 There was one designated full-time custody suite for the borough at Walworth Road, which had 30 cells. There was a custody manager for the borough, who on occasions was required to cover the custody support inspector role.

3.7 Staffing in the custody suite was adequate and comprised permanent custody sergeants, who were line managed by the custody manager and two custody support inspectors. Management was shared with the borough of Lewisham, which also provided a custody manager and two custody support inspectors. There were some delays in inspector reviews which the borough had identified and was working to resolve. Custody trained backfill sergeants from response or neighbourhood duties were used to cover for custody sergeant absences.

3.8 Custody sergeants were supported by permanent designated detention officers (DDOs). DDOs were responsible for the ongoing care and welfare of detainees and were line managed by the custody sergeants.

3.9 DDOs had received training to book in detainees under the supervision of custody sergeants but we did not witness this during our inspection.

3.10 Three times a day there was an operational meeting in the borough usually chaired by a member of the SLT. This meeting was attended by a custody representative who could raise custody issues as necessary. Custody was also discussed at the fortnightly SLT meeting attended by the chief inspector custody lead. There was a monthly custody management meeting, chaired by the chief inspector custody lead, attended by the custody manager, custody support inspector and a custody sergeant representative. Custody was an agenda item at the quarterly BOCU health and safety meeting, which the chief inspector custody lead attended.

3.11 There was a good process in place to quality assure custody work, with an organisational expectation to check a 10% sample of custody records, which the borough had exceeded for the month of October 2013. The TPCJ template for dip sampling of custody records was comprehensive and included the checking of prisoner escort record (PER) forms and CCTV recordings. The chief inspector custody lead had taken ownership of this process and was undertaking the majority of custody record dip sampling, with some input from the custody support inspectors and custody support sergeant. The custody manager and custody support inspectors needed to be more involved in this process, with the chief inspector providing an overview. There was a clear audit trail of feedback to officers through the completion of the management action template. Custody staff informed us that they received feedback from this process. In addition to the custody record dip sampling, there was monthly themed focus on specific areas, for example the recording of the handover process on the custody record.

3.12 There were effective processes for dealing with successful interventions, with custody sergeants completing a computerised form which was forwarded to the TPCJ, the custody manager, the borough health and safety manager and the police federation representative. The chief inspector had oversight of successful interventions, which were an agenda item on the borough quarterly health and safety meeting and the custody management meeting. Learning points from successful interventions and the quality assurance process were communicated to staff via email from the chief inspector, who followed this up by personally checking with staff. Independent Police Complaints Commission (IPCC) 'learning the lessons' information was added to the TPCJ intranet site, which also contained policies and standard operating procedures, and staff were expected to visit the site regularly to update themselves. However, there was limited awareness among staff of how to access the TPCJ intranet site.

Housekeeping points

3.13 All members of the SLT should undertake and record visits to the custody suite as outlined in the borough's custody risk register.

3.14 The custody manager and custody support inspectors should be more involved in the quality assurance process.

Good practice

3.15 The use of the management action template, to record actions resulting from the dip sampling of custody records, provided a clear audit trail of feedback to officers.

Partnerships

3.16 There was engagement with partners at a strategic level. The borough commander attended the local Health and Wellbeing Board. A detective chief inspector represented the borough at the joint performance meeting with criminal justice partners and the partnership superintendent met regularly with the Director of Children's Services and the Youth Offending Services manager.

3.17 There was an established independent custody visitor (ICV) scheme covering the borough, with a weekly visit to the suite and an additional visit each month. Immediate issues were dealt with effectively and feedback received on outstanding issues. Police regularly attend panel meetings.

3.18 The borough and the Metropolitan Police were unable to provide any data on voluntary attendance and therefore could not evidence its use where appropriate. Staff showed inspectors an instruction issued by senior management stating that Code G of PACE was only to be used in exceptional circumstances. This was incompatible with Article 5 of the European Convention of Human Rights[4] (see paragraph 5.1 and main recommendations 2.29 and 2.30).

Recommendation

3.19 The Metropolitan Police should introduce a process for recording and monitoring voluntary attendance at police stations.

Learning and development

3.20 All DDOs and custody sergeants had received training before working in custody. Custody refresher training was provided for custody sergeants and DDO's, and staff we spoke with had either received this training or were scheduled to attend.

[4] Article 5 of the European Convention of Human Rights states that: 'Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in specific cases (outlined in the Article 5) and in accordance with a procedure prescribed by law.'

Section 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 We observed custody sergeants interacting with detainees respectfully and dealing with some very confrontational detainees, including situations at the booking in desk, in a firm but appropriate manner. Abusive language was appropriately challenged. Although the majority of designated detention officers (DDOs) were respectful towards detainees, some were abrupt and abrasive, particularly when speaking to them via the cell call bell intercom (see paragraph 4.34). Detainees told us that they felt that they had, in the main, been treated respectfully by custody staff.

4.2 The custody suite was a large environment and had been refurbished, re-opening in May 2013. The four booking in terminals were separated by screens so there was reasonable privacy. However, this was undermined by the number of non-custody staff moving around the custody suite (see also paragraph 4.19). There was a 'discrete' booking-in room that afforded excellent privacy. This was primarily used for bail returnees and could be used to book in detainees with sensitive offences.

4.3 Girls aged16 or under were not allocated a named female officer responsible for their care, but women coming into custody were asked if they wanted to speak to a female officer. There was a useful leaflet for female detainees outlining what they could expect from custody staff with regard to their care, and providing reassurance that their welfare was paramount while they were held in custody. It was disappointing that the leaflet was only available in English and was not given to any of the women detainees we saw being booked in.

4.4 There was a lack of provision for children and young people. There was no particular focus on limiting children and young people's time in custody, or common methods for dealing with them while they were there. Some custody staff placed young people in cells closest to the custody desk and in the quietest corridor, whereas others did not give consideration to cell location. However we did observe some considered and appropriate responses, for example, a 16-year-old sat in a consultation room with his appropriate adult (AA), before being brought to the front desk to be charged. Custody staff told us that they would always try to facilitate this if there were no indentified risks and if the custody suite was quiet, which was encouraging.

4.5 Custody staff had received safeguarding training as part of their initial training package and some of the DDOs we spoke to provided good examples of what they would do if a young person raised a safeguarding issue, which is something we rarely see during inspections.

4.6 There was limited provision for disabled detainees. One cell was labelled 'DDA' because it had three lowered cell call bells, by the door, toilet and bed plinth. However, all the bed plinths were too low, and there were no thick mattresses to raise the height, which meant that it would not be accessible to older detainees or those with disabilities. There was a hearing loop at each of the booking in terminals which was always switched on.

4.7 The suite had a good stock of suitable prayer mats and copies of the Bible, Qur'an and other holy books. Some of the religious artefacts which should have been stored in the 'diversity box' were carelessly left on top of the shelf. There was no means of reliably determining the direction of Mecca for Muslim detainees in the cells or cell corridors.

4.8 Staff were able to discuss how they would search transgender detainees, although they had never done so, and they accurately referred to what they had been taught in their training. We saw all detainees being asked if they had any obligations to care for any dependants.

Recommendation

4.9 The Metropolitan Police Service should develop procedures that encourage custody staff to consider and respond to the distinct needs of children and young people in custody.

Housekeeping points

4.10 Girls aged 16 or under should be allocated a female member of staff responsible for their care.

4.11 All women should be offered the leaflet with specific information for female detainees.

4.12 A supply of thick mattresses should be available to raise the height of the bed plinths for detainees that require it.

4.13 There should be a means for indicating the direction of Mecca.

Safety

4.14 Custody sergeants booked in detainees and asked a set of questions about health, risk and individual needs contained in the national strategy for police information systems (NSPIS) custody record system. The system was linked to the police national computer (PNC) and any warning markers concerning risk were immediately visible. We saw custody sergeants asking appropriate supplementary questions when detainees disclosed potential risks. On one day during the inspection a volatile detainee was refusing to engage in the booking in process. The custody sergeant checked the PNC, which highlighted that there were mental health issues, and sensitively discussed this with the detainee. The detainee calmed down and became more willing to engage in the process, which enabled the custody sergeant to gather more information to look after her needs appropriately. This was skilfully and considerately done.

4.15 In our custody record analysis all detainees were risk assessed on arrival into custody, although in one or two cases parts of the risk assessment had not been completed because the detainee was being violent or refused to answer any questions. In these cases, custody sergeants took available information into account, such as the demeanour of the detainee and whether they appeared intoxicated. Risk assessments contained a good level of detail.

4.16 Custody sergeants were proportionate in managing risk and did not routinely remove detainees' shoes or clothes, using the risk assessment to determine the level of management required. Several constant supervisions were conducted during the inspection and were well managed. Most were undertaken by police officers, who were thoroughly briefed and gave detainees their full attention, recording anything of note. During the inspection two police officers conducted a constant supervision of a female detainee, and sat in the cell with her and engaged her in conversation. When we spoke to officers and DDOs about constant supervisions they believed that interacting with the detainees, where appropriate, was important to try and reassure and calm detainees down.

4.17 Intoxicated detainees were subject to rousing checks. The '4-Rs' mnemonic (rousing procedure as set out in annex H to code C in the Police and Criminal Evidence Act 1984), was in use as a reminder to staff, who fully understood the importance of obtaining a response during rousals. All cells were monitored by CCTV. There were no stocks of safety clothing.

4.18 The levels of observations that detainees were placed on varied and appeared appropriate. Custody sergeants altered the level of observations, sometimes in discussion with the health care professional on site. Custody records showed that the stated level of observation was always adhered to. In one or two instances where observation checks were late (up to 10–15 minutes) the reason for the delay was always noted and usually related to an incident in custody or a large number of detainees on rousals, which was good to see.

4.19 Custody staff had personal single-use anti-ligature knives, but not all DDOs carried them on their person, despite our previous recommendation. The cell keys had anti-ligature knives attached but the management of cell keys was poor. We observed non-custody staff taking cell keys and accessing detainees, which was not appropriate. This could also mean that where a cell needed to be unlocked in an emergency, custody staff might not be able to readily access a set of keys.

4.20 Handovers between shifts were not all well conducted. Custody staff did not clear the custody suite during one handover and were still booking in detainees when the handover had begun. A second handover we observed was better conducted with detailed, accurate information passed to the incoming shift, but did not involve the DDOs. We observed the incoming custody sergeants going to each cell and introducing themselves to all the detainees, and the handover notes we reviewed in the custody records were thorough. The DDOs had a separate handover where risks were not always identified or passed on to latecomers.

4.21 A leaflet containing details of support organisations was explained to all detainees being bailed or discharged, although it was available only in English. Custody sergeants routinely asked detainees if they wanted them to contact the agencies on their behalf. We observed some excellent pre-release assessments during the inspection where custody sergeants had concerns about the welfare or detainees. They asked questions to establish whether they had sufficient support on release, involved the health care practitioner and substance misuse worker where necessary and demonstrated good care regarding the welfare of detainees. This was further supported in our custody record analysis which found that the level of detail was generally good in the pre-release risk assessments.

4.22 Custody sergeants had no access to travel warrants or money for transport costs, but they told us that they arranged for officers to take any particularly vulnerable detainees home and only released young people when they were accompanied by an AA or police officer.

Recommendations

4.23 Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees.

4.24 Information about support agencies should be available in a range of languages in addition to English.

4.25 All custody staff should carry ligature knives when visiting detainees in their cells.

Housekeeping point

4.26 Non-custody staff should not have access to cell keys and custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised.

Use of force

4.27 Not all detainees were handcuffed on arrival at the custody suite. Detainees brought into the custody suite during the night told us that their cuffs were removed when they were brought to the booking in desk. There were exceptions to this; one concerned a volatile detainee who was kept in handcuffs until she had calmed down, which was a suitable response to the risk that she first presented. The other exception we observed was not appropriate and concerned a foreign national detainee who went through half of the booking in process, conducted via a telephone interpreter, while handcuffed. The handcuffs were only removed when the custody sergeant saw that the detainee was struggling to hold the telephone handset.

4.28 Very few detainees were strip-searched and those that we saw being authorised were proportionate. This was further supported by our custody record analysis where eight detainees in the sample were strip-searched, all of which were proportionate. Strip searches were undertaken in a room designated for the purpose, with no CCTV.

4.29 There was no use of force recording form. Custody sergeants told us that they recorded uses of force on the NSPIS system, and this was confirmed by the custody record analysis. They sought to preserve evidence of any injuries (for example, by taking a photograph) and arranged for such detainees to see a health care practitioner. Information on the use of force in custody suites was not collated locally or force-wide. All staff had been trained in approved safety techniques and received annual refresher training.

Housekeeping point

4.30 Subject to risk assessment, detainees should have their handcuffs removed as soon as possible.

Physical conditions

4.31 The custody suite had recently been refurbished, and most cells were clean. All had minimal natural light. Some of the cells (those in corridor 1-11) were too cold and we observed detainees who had been held overnight shivering in their cells (see paragraph 4.41). Some cells had graffiti etched on bed plinths.

4.32 On one day during the inspection, eight of the 30 cells were out of use. Three cells had been out of use for three weeks due to blocked toilets, two cells required attention from the maintenance contractors due to a faulty door hatch and intercom and a further three required cleaning. Staff told us that it was common to have some cells out of use as cleaning contractors only attended the custody suite in the morning. This was poor management of cell capacity and inadequate cleaning arrangements for a very busy custody suite.

4.33 We observed cells checks being conducted and recorded by a DDO, which were thorough included the checking of ligature points, intercom, lights, mattresses and pillows. However there were missing records, indicating that the cells were not checked on a daily basis. There were appropriate arrangements for cleaning bodily fluid spills. The holding room, consultation rooms and interview rooms were all clean and tidy.

4.34 The cell call bells sounded clearly and were promptly answered, but despite a recommendation made at the last inspection detainees were still not told how and when to use the cell call bell when they were taken to the cells. We heard some DDOs responding very abruptly to agitated detainees rather than dealing with them calmly and in a reassuring tone. An intercom system allowed external telephone calls to be put through to the cells and we observed some detainees having telephone calls from family and friends.

4.35 There had been no emergency practice evacuation held in the previous year and no records of any practice evacuations. Custody staff could only recollect a real evacuation in 2006. There was a comprehensive emergency evacuation plan, with which staff were familiar. Adequate stocks of handcuffs were readily accessible.

Recommendations

4.36 Cleaning staff should be available morning and afternoon to minimise the number of cells out of use.

4.37 The ongoing maintenance problems should be resolved.

Housekeeping points

4.38 Cell checks should be completed daily and recorded.

4.39 Emergency practice evacuations should be conducted and any lessons learned recorded and disseminated to custody staff.

4.40 Detainees should have the cell call bell explained to them when they are located in a cell.

Detainee care

4.41 Many of the recommendations we made at the last inspection concerning detainee care had not been achieved. This was disappointing and continued to adversely impact detainees' overall care and treatment while in custody. There were adequate stocks of clean pillows, mattresses and blankets. During the inspection we observed some detainees in very cold cells. They had each been given one blanket but this was insufficient. One detainee who we spoke to confirmed that he was cold and said that it had taken him nearly an hour to get a blanket after his initial request. DDOs told us that if detainees required a second blanket they would need to ask, but this offered inadequate care. The blanket storage cupboard contained sufficient boxes of new blankets that could have been issued. A room containing dirty blankets was overflowing and staff were unable to explain why there were so many waiting to be collected for cleaning.

4.42 Detainees whose clothing had been seized or was soiled were provided with t-shirt and tracksuit bottoms and there was a sufficient supply in a range of sizes, including plimsolls. There were no paper suits. Replacement underwear was not available. There were adequate stocks of toiletries, including toothpaste, soap and feminine hygiene products. Women were not routinely told about the availability of hygiene packs but there were notices clearly displayed on the walls in each of the cell blocks.

4.43 Clean cotton towels were available. Three showers provided hot water and good privacy, although they were rarely used. Detainees we spoke to prior to attending court and those held overnight were not offered a shower. Disappointingly, given the proportionate risk management, detainees had to ask if they wanted toilet paper. Images of toilet areas were obscured on the CCTV monitors, but detainees were not informed of this.

4.44 Breakfast and lunch was provided by the onsite canteen. Outside of these times a wide range of microwave meals, including some that were appropriate for vegetarian and halal diets, were offered to detainees throughout the day. The meals provided by the canteen looked appetising and the portions reasonable. During the inspection a detainee who was being released from custody told the custody sergeant that he was hungry, and a meal from the canteen was provided for him, which was considerate. The microwave ovens were clean. Tea, coffee and water were freely available.

4.45 The two exercise yards were full of rubbish. During the inspection a detainee who was very upset was offered some time in the exercise yard to calm down. Aside from this detainees were not routinely offered time in the exercise yard. We were told that social visits were allowed very occasionally in exceptional circumstances and custody sergeants were able to provide examples of when this was done.

4.46 There were few reading materials available. We found some books and copies of a free newspaper and magazines that staff had brought in. Despite the limited range detainees we spoke to told us that they were not offered any reading material. In our custody record analysis, none of the 30 detainees whose records we scrutinised had received a shower, exercise, or reading materials, which was poor.

Recommendation

4.47 Cells should be kept a reasonable temperature and detainees should not be located in cold cells.

Housekeeping points

4.48 Detainees should be offered more than one clean blanket and told they can ask for more.

4.49 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.

4.50 Subject to individual risk assessment, a small supply of toilet paper should be routinely placed in each cell.

4.51 Staff should tell detainees that they cannot be seen using the toilet.

4.52 The exercise yard should be cleaned properly and its cleanliness should be regularly maintained. Detainees should be offered time outside in the exercise yard.

4.53 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy.

4.54 Replacement underwear should be available.

Section 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 Custody sergeants were able to give examples of occasions when they had refused to detain because they considered it unnecessary to bring a detainee into custody. They believed that alternatives to arrest and detention, such as street bail or voluntary attendance at the police station were under-used. Arresting offices were aware of Code G of PACE[5] but we were told that not all acted in accordance with it (see main recommendation 2.30). Some custody sergeants said there was an impetus to increase arrest figures. Staff had received instruction from the senior management team to use voluntary attendance only in exceptional circumstances, which was inappropriate and not a lawful order.

5.2 Most detainees were booked in promptly on arrival, despite the custody suite being busy. We observed investigations being progressed reasonably quickly, with detainees being charged or bailed up until midnight or from 7.30am. However, during the inspection few detainees were dealt with during the night.

5.3 Custody staff described a good working relationship with Home Office immigration enforcement staff, who usually informed them in advance if an operation in the area might result in many detainees being brought into custody. We were told that immigration enforcement staff provided the necessary authority to detain (form IS91) on the day of arrest and detainees were normally taken to a more suitable place of detention within 48 hours.

5.4 Family members were used as appropriate adults (AAs) whenever possible. When no family members were available, AAs for young people up to 18 years old were provided by the youth offending team (YOT) during office hours; or until 11pm and at weekends by a group of volunteers trained and supervised by social services. The volunteers also acted as AAs for any vulnerable adults, including during office hours. We spoke with two AA volunteers who felt well supported both by the scheme's organisers and by custody staff. We observed them attend the custody suite promptly, but we could not verify if this was always the case because custody records did not record arrival times. AAs would not normally support detainees who did not wish to have the services of a legal adviser, and we were concerned that might result in some detainees' preferences not being respected. Custody staff involved health care professionals appropriately in deciding if a potentially vulnerable adult needed an AA.

5.5 We were told that staff would always try to find an overnight placement via social services for any young person who could not be bailed or released before night time, but that such placements were never available. Our custody record analysis raised concerns about a 13-year-old who was kept in custody overnight. Custody staff requested an overnight secure placement with social services, which was not available. There were no indications that a

[5] Code G of PACE deals with statutory power of police to arrest persons suspected of involvement in a criminal offence.

non-secure placement had been considered or requested and he was kept in custody for 17 hours 29 minutes.

Recommendation

5.6 The Metropolitan Police Service should work with local social services departments to ensure the availability of suitable alternative accommodation for young people facing an overnight stay in police custody.

Housekeeping point

5.7 The local authority should ensure that its appropriate adult volunteers attend the police station to support detainees who are capable of understanding that legal advice is available and that it may benefit them, but who nevertheless do not wish to accept it.

Rights relating to PACE

5.8 Custody sergeants explained rights and entitlements to detainees during booking in and told them these could be exercised at any time. All detainees were given an information sheet about rights and entitlements, but the information was poorly presented and potentially difficult to read. Custody sergeants were not aware of the 'easy read' version of the information available on the Home Office website. Rights and entitlements in other languages could be downloaded from the force intranet, though some custody staff struggled to find the information. Nevertheless, we spoke with a detainee who had been given a copy in his first language, Arabic.

5.9 There were plenty of posters from the Criminal Defence Service about obtaining a solicitor on display, including in other languages. A private booth for telephone consultation with legal advisers was provided.

5.10 A professional telephone interpreting service was in use for interpretation, via a two-handset telephone. We saw a telephone interpreter obtained immediately for one detainee being booked in.

5.11 There were no up to date copies of the PACE Codes of Practice available (except the new Code G booklet). The 2006 edition was in use, and one custody sergeant was unsure what would be given to a detainee who asked to see the Code of Practice.

5.12 Commendably, many PACE reviews were undertaken in person, but we saw some that were very brief, with the inspector giving information about entitlements without attempting to ask the detainee if they had any concerns or questions, which could have compromised the detainee's care. Another inspector did ask detainees if they had any questions or complaints, and those reviews were better.

5.13 Custody sergeants told us that the requirement that each custody support inspector undertook reviews of detention at both Southwark and Lewisham meant that reviews were either late or took place unreasonably early, as it could take a long time to travel between the two suites. Our custody record analysis found that of the 19 detainees who required an initial review, five were conducted on time, five were late, and nine took place early. Some were conducted only two or three hours after detention had been authorised, which is not in the spirit of PACE. Four reviews were conducted when the detainee was asleep. In only

one case had the detainee been told of the review on waking and reminded of their rights and entitlements, which was poor.

5.14 Legal advisers told us they believed their clients were generally well treated, though one was concerned about delays in obtaining charging decisions from the Crown Prosecution Service, which he said often took four to five hours.

5.15 The local magistrates' court would not normally accept detainees after 1pm on weekdays and first thing on Saturday morning. That was far too early, resulting in detainees who were not charged until later in the morning remaining in custody overnight, which was detrimental to detainee care. A virtual court was available via video link most days, though the criteria for suitability were not always followed. Illogical decisions were sometimes made about who would, and who would not attend virtual court.

5.16 For example, a detainee who did not consent to attending court was allocated to the virtual court. The virtual court was not ready for him until midday, when he refused to leave his cell for the hearing. As a result he had to be conveyed by police officers to the magistrates' court. Staff told us there were regular instances when virtual court cases were not heard until the afternoon, when no prisoner transport vehicle would be available to take those remanded or sentenced to prison. That resulted in them staying in police custody, without the entitlements that a prisoner should have, for an extra night.

5.17 A Criminal Justice System leaflet for defendants about virtual court was available. It listed all the benefits of opting to go to virtual court (such as getting the case dealt with quickly) but none of the potential disadvantages, which was unacceptable.

Recommendations

5.18 Information about detainees' rights and entitlements should always be available in a range of formats to meet specific needs.

5.19 Up-to-date copies of relevant PACE codes of practice should be available.

5.20 Sufficient inspectors should be designated to undertake PACE reviews of detention, which should be completed on time, with detainees invited to make representations.

5.21 The Metropolitan Police Service should engage with HM Courts and Tribunals Service to ensure that the virtual court, and early court cut-off times, do not result in unnecessarily long stays in police custody.

5.22 The Ministry of Justice should revise the Criminal Justice System leaflet for defendants about virtual court so that it provides a more balanced view of the benefits and drawbacks of appearing.

Housekeeping points

5.23 Detainees whose reviews are conducted while they are asleep should be told of the review, and reminded of their rights on waking, and this should be noted in the custody record.

5.24 Custody sergeants should be briefed about how to operate the criteria for virtual court.

Rights relating to treatment

5.25 Detainees were not provided with information about how to make a complaint. Some custody staff told us that detainees wanting to complain would have to go to the police station front desk unless it was a very minor matter that the custody sergeant could resolve while the detainee was in custody. Others told us that the custody support inspector would take details of the complaint and initiate its investigation. There were no Independent Police Complaints Commission (IPCC) leaflets about how to make a complaint.

Recommendation

5.26 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to, complaints should be taken while they are still in police custody.

Section 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.

Governance

6.1 The Metropolitan Police Service (MPS) provided health services. Custody staff reported that the move from an on-call doctor-led service to having a custody nurse practitioner (CNP) onsite 24 hours a day had improved response times and communication. Monitoring arrangements were good and clinical governance arrangements were robust.

6.2 The CNP was supported by on-call forensic medical examiners (FMEs) who covered several suites. CNPs from another suite covered any staffing shortages. The MPS checked staff credentials and offered comprehensive initial and ongoing mandatory training. Health staff received regular managerial supervision and performance reviews, but clinical supervision was informal and was not recorded.

6.3 The CNP did not attend custody shift handovers but we saw ongoing effective information sharing and risk management between the CNP and custody staff. CNPs emailed handover information to each other to ensure continuity of care.

6.4 Interpreting services were available and we observed a consultation which used a face-to-face interpreter. Consent to share information with GPs and other professionals was obtained on a case by case basis.

6.5 The clinical room was clean and well resourced, but the counter top and sinks were not fully compliant with infection control guidelines. There was no privacy screening for use during intimate sampling which severely impacted patient privacy and dignity. All clinical stock was in date, appropriate and well managed.

6.6 Resuscitation equipment, including portable suction and an automated external defibrillator, was stored in the main booking in area and received daily recorded checks. All custody staff were trained in emergency first aid. Oxygen was stored in the clinical room, but there was no equipment to keep an airway open, which could severely reduce the effectiveness of resuscitation.

Recommendation

6.7 The clinical room should have adequate privacy screening and fully comply with NHS environmental infection control standards.

Housekeeping points

6.8 All health staff should have access to regular recorded clinical supervision.

6.9 The emergency resuscitation equipment should include an appropriate selection of airways that all staff are trained to use.

Patient care

6.10 Custody staff referred detainees to the CNP based on assessed need or detainee request. CNPs checked the custody computer system regularly to identify and prioritise detainees who required assessment. FME input was requested as needed and we were advised that response times were reasonable, which was confirmed by our custody record analysis.

6.11 We observed several respectful, clinically appropriate consultations with detainees, which included effective risk identification and management. However detainees were routinely seen with the door open with custody staff observing from the corridor, which compromised confidentiality.

6.12 CNPs made comprehensive electronic clinical records and duplicated a brief summary and care instructions for custody staff on the custody system. Paper records, including illustrated body maps, were stored securely. FMEs recorded on the custody system and kept their own paper records, but we were not assured that these were consistently stored in accordance with Caldicott guidelines[6]. The electronic clinical records we sampled were very good.

6.13 CNPs prescribed and administered medication via patient group directions (which enabled nurses to supply and administer prescription-only medicine) and recorded it in a book and on the clinical record, which provided an effective audit trail. FMEs were contacted if other medicines or higher doses were indicated. Symptomatic relief was offered for opiate and alcohol withdrawals if clinically indicated and community prescribed Methadone and Buprenorphine could be continued.

6.14 Detainees' own medication was stored securely by custody staff. There were effective systems to collect detainees' own medication or obtain an alternative supply. Thirty per cent of the detainees in our custody record analysis reported being on medication and all who required it received medication while in custody.

6.15 Medicine stock management was good and medication including controlled drugs was stored securely, except for heat-sensitive medications which were stored in an unlocked fridge where temperatures were not monitored. All stock was in date, although weekly checks were not consistently completed. Controlled drugs were stored safely and records were correct. Nicotine replacement therapy was not available.

Recommendations

6.16 Health care professionals should keep the medical room door closed when seeing a detainee, except when a risk to safety has been identified.

6.17 All clinical records should meet professional standard requirements and be held securely in accordance with Caldicott guidelines.

6.18 Nicotine patches should be available for detainees held for substantial periods. (Repeated recommendation 6.38)

---

[6] Caldicott guidelines are the general principles that health and social care organisations should use when reviewing their use of client information.

Housekeeping point

6.19 Heat-sensitive medication should be stored securely in a lockable fridge.

Substance misuse

6.20 Southwark Drug Intervention Programme (DIP) team provided support for adults with drug and alcohol issues. The service included assessment, case management and appropriate referral to other support services, including opiate substitution prescribing, specialist alcohol workers, housing and benefits support. A worker was based at the suite daily and a duty worker accepted referrals out of hours. Custody staff referred detainees with mandated treatment requirements and those requesting support. Additionally the drug worker visited the cells throughout the day to offer detainees a service, which ensured equitable access. Detainees from outside the borough were assessed and referred to their local service. The drug worker maintained separate records and did not record on the custody system.

6.21 There was no provision to provide clean injecting equipment from the suite, although the drug worker informed detainees about local syringe exchange services.

6.22 Detainees under the age of 18 were referred to specialist young people services as required.

Housekeeping point

6.23 Southwark Drug Intervention Programme team members should record on the custody record system.

Mental health

6.24 The police had appropriate arrangements in place to discuss strategic issues with mental health authorities, and informal relationships between the organisations were good.

6.25 There was no mental health diversion service. Detainees who reported they were involved with mental health services were referred to their own team if necessary. Detainees with suspected severe mental health issues who may have required detention under the Mental Health Act 1983 were referred to the Approved Mental Health Professional (AMHP) team at South London and Maudsley NHS Foundation Trust. We were advised that the AMHP team was generally helpful but there were often significant delays in assessment and occasionally delays in obtaining an appropriate hospital bed. The AMPH team did not record on the custody record, but health and custody staff recorded the outcome of the assessment.

6.26 Twenty per cent of detainees in our custody record analysis reported mental health problems. We were concerned that the lack of a mental health diversion scheme meant that detainees with less severe mental health issues were not appropriately supported. Additionally CNPs spent significant periods liaising with mental health teams which meant other detainees waited longer to be seen. Custody staff did not receive any ongoing mental health training to help them identify and support detainees with mental health problems.

6.27 Four Section 136 suites were shared with three other boroughs and usage was not separated by borough. We were advised that there had been a 25% increase in demand since March 2013 and the suites were used an average of 50 times a month. Thirty-five to 45% of all persons detained under Section 136 were discharged back to the community within a few

hours. The custody suite had been used as a place of safety eight times in 2013 which was similar to previous years.

Recommendations

6.28 There should be a consistent and comprehensive mental health liaison and diversion scheme which enables detainees with mental health problems to be identified and diverted into appropriate mental health services.

6.29 All custody staff should receive regular mental health awareness training to identify and manage the care of detainees appropriately and safely.

Section 7. Summary of recommendations

Main recommendations

7.1 The Metropolitan Police Service should collate use of force data in accordance with Association of Chief Police Officers' policy and National Policing Improvement Agency guidance to monitor uses, identify trends and establish learning for the force. (2.28)

7.2 The instruction that Code G of PACE should only be used in exceptional circumstances should be immediately withdrawn. (2.29)

7.3 The Metropolitan Police Service should ensure officers comply with Code G of PACE and develop provisions such as street bail and voluntary attendance. (2.30)

Recommendations

Strategy

7.4 The Metropolitan Police should introduce a process for recording and monitoring voluntary attendance at police stations. (3.19)

Treatment and conditions

7.5 The Metropolitan Police Service should develop procedures that encourage custody staff to consider and respond to the distinct needs of children and young people in custody. (4.9)

7.6 Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees. (4.23)

7.7 Information about support agencies should be available in a range of languages in addition to English. (4.24)

7.8 All custody staff should carry ligature knives when visiting detainees in their cells. (4.25)

7.9 Cleaning staff should be available morning and afternoon to minimise the number of cells out of use. (4.36)

7.10 The ongoing maintenance problems should be resolved. (4.37)

7.11 Cells should be kept a reasonable temperature and detainees should not be located in cold cells. (4.47)

Individual rights

7.12 The Metropolitan Police Service should work with local social services departments to ensure the availability of suitable alternative accommodation for young people facing an overnight stay in police custody. (5.6)

7.13 Information about detainees' rights and entitlements should always be available in a range of formats to meet specific needs. (5.18)

7.14 Up-to-date copies of relevant PACE codes of practice should be available. (5.19)

7.15 Sufficient inspectors should be designated to undertake PACE reviews of detention, which should be completed on time, with detainees invited to make representations. (5.20)

7.16 The Metropolitan Police Service should engage with HM Courts and Tribunals Service to ensure that the virtual court, and early court cut-off times, do not result in unnecessarily long stays in police custody. (5.21)

7.17 The Ministry of Justice should revise the Criminal Justice System leaflet for defendants about virtual court so that it provides a more balanced view of the benefits and drawbacks of appearing. (5.22)

7.18 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to, complaints should be taken while they are still in police custody. (5.26)

Health care

7.19 The clinical room should have adequate privacy screening and fully comply with NHS environmental infection control standards. (6.7)

7.20 Health care professionals should keep the medical room door closed when seeing a detainee, except when a risk to safety has been identified. (6.16)

7.21 All clinical records should meet professional standard requirements and be held securely in accordance with Caldicott guidelines. (6.17)

7.22 Nicotine patches should be available for detainees held for substantial periods. (6.18, repeated recommendation 6.38)

7.23 There should be a consistent and comprehensive mental health liaison and diversion scheme which enables detainees with mental health problems to be identified and diverted into appropriate mental health services. (6.28)

7.24 All custody staff should receive regular mental health awareness training to identify and manage the care of detainees appropriately and safely. (6.29)

Housekeeping points

Strategy

7.25 All members of the SLT should undertake and record visits to the custody suite as outlined in the borough's custody risk register. (3.13)

7.26 The custody manager and custody support inspectors should be more involved in the quality assurance process. (3.14)

Treatment and conditions

7.27 Girls aged 16 or under should be allocated a female member of staff responsible for their care. (4.10)

7.28 All women should be offered the leaflet with specific information for female detainees. (4.11)

7.29 A supply of thick mattresses should be available to raise the height of the bed plinths for detainees that require it. (4.12)

7.30 There should be a means for indicating the direction of Mecca. (4.13)

7.31 Non-custody staff should not have access to cell keys and custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.26)

7.32 Subject to risk assessment, detainees should have their handcuffs removed as soon as possible. (4.30)

7.33 Cell checks should be completed daily and recorded. (4.38)

7.34 Emergency practice evacuations should be conducted and any lessons learned recorded and disseminated to custody staff. (4.39)

7.35 Detainees should have the cell call bell explained to them when they are located in a cell. (4.40)

7.36 Detainees should be offered more than one clean blanket and told they can ask for more. (4.48)

7.37 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.49)

7.38 Subject to individual risk assessment, a small supply of toilet paper should be routinely placed in each cell. (4.50)

7.39 Staff should tell detainees that they cannot be seen using the toilet. (4.51)

7.40 The exercise yard should be cleaned properly and its cleanliness should be regularly maintained. Detainees should be offered time outside in the exercise yard. (4.52)

7.41 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy. (4.53)

7.42 Replacement underwear should be available. (4.54)

Individual rights

7.43 The local authority should ensure that its appropriate adult volunteers attend the police station to support detainees who are capable of understanding that legal advice is available and that it may benefit them, but who nevertheless do not wish to accept it. (5.7)

7.44 Detainees whose reviews are conducted while they are asleep should be told of the review, and reminded of their rights on waking, and this should be noted in the custody record. (5.23)

7.45 Custody sergeants should be briefed about how to operate the criteria for virtual court. (5.24)

Health care

7.46 All health staff should have access to regular recorded clinical supervision. (6.8)

7.47 The emergency resuscitation equipment should include an appropriate selection of airways that all staff are trained to use. (6.9)

7.48 Heat-sensitive medication should be stored securely in a lockable fridge. (6.19)

7.49 Southwark Drug Intervention Programme team members should record on the custody record system. (6.23)

Good practice

7.50 The use of the management action template, to record actions resulting from the dip sampling of custody records, provided a clear audit trail of feedback to officers. (3.15)

Section 8. Appendices

Appendix I: Inspection team

Elizabeth Tysoe	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Paul Davies	HMIC lead staff officer
Mark Ewan	HMIC staff officer
Majella Pearce	HMIP health services inspector
Laura Nettleingham	HMIP researcher

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made for the Walworth Road custody suite. (We have not included previous recommendations for the Peckham and Southwark suites as these are no longer in use.) The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Strategy

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

Recommendations to the Metropolitan Police Service (MPS)

The Metropolitan Police Service (MPS) should establish the extent to which identified weaknesses in custody practices and procedures have been exacerbated by the lack of a permanent custody team and the institution of 12-hour shifts, and take action accordingly. (3.15)
Achieved

All custody staff should undergo nationally approved custody officer training. (3.16)
Achieved

The MPS should consult with the Crown Prosecution Service (CPS) with the aim of developing an effective bail management system that minimises use of custody. (3.17)
Achieved

A protocol should be developed governing the access of independent custody visitors (ICVs) to information on National Strategy for Police Information Systems (NSPIS). (3.18)
Achieved

There should be an effective procedure for following up and monitoring progress on internal inspections. (3.19)
Achieved

Recommendations to UKBA and MPS

The UK Border Agency (UKBA) should regularly monitor the physical conditions in which detainees are held on its behalf by the Metropolitan Police. (3.20)
No longer relevant

There should be clear operating instructions and standards to regulate the use of police cells for immigration detainees set down by the UKBA that incorporates the following:

- The UKBA should ensure that immigration detainees are held for the shortest possible time in police cells.

- The UKBA should review detention expeditiously and keep detainees informed of case progress in a language they can understand.
- Immigration officials should serve and explain to detainees decision documents that have important consequences or engage appeal rights.
- Police custody officers should communicate daily with the UKBA to ensure speedy case progression. (3.21)

No longer relevant

Treatment and conditions

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

Recommendations

Custody staff should receive specialist training in the management of self-harm behaviour. (4.76)
Partially achieved

All custody staff should carry personal cell keys and ligature knives secured to their person. (4.47)
Not achieved (recommendation repeated, 4.24)

Detainees should be told how to operate cell call bells. (4.48)
Not achieved (recommendation repeated as a housekeeping point 4.39)

Cells and all other areas should be cleaned in accordance with the Metropolitan Police Authority operational custody suite cleaning contract. A daily cleaning schedule should be monitored and enforced by a designated officer. (4.79)
No longer relevant (new recommendation, 4.35)

Every detainee staying overnight should be offered at least two clean blankets and a clean pillowcase and told they can ask for more. (4.80)
Partially achieved (recommendation repeated as a housekeeping point, 4.47)

Cells should be kept at a reasonable temperature. (4.81)
Not achieved (recommendation repeated, 4.46)

Detainees should routinely be given an adequate amount of toilet paper and told they can request more. (4.82)
Not achieved (recommendation repeated as a housekeeping point, 4.49)

Detainees should not be given paper suits to wear except for forensic purposes to preserve evidence. A clear policy on when paper suits should be used should be published. (4.83)
Achieved

All detainees should have access to washing facilities and told they can request a shower. (4.84)
Not achieved (recommendation repeated as a housekeeping point, 4.48)

A stock of reading material should be available to detainees, including newspapers, religious texts and material in languages commonly spoken by detainees. (4.85)
Not achieved (recommendation repeated as a housekeeping point, 4.52)

Detainees held for a day or more, or otherwise in need of a change of clothing, should be offered basic clothes, including a change of underwear. (4.86)
Partially achieved (recommendation repeated as a housekeeping point, 4.53)

Visits to detainees should be allowed when possible, and should particularly be facilitated when the detainee has been in custody for longer than 24 hours. (4.87)
Achieved

Custody suite staff should receive fire safety training and evacuation plans should be practised. (4.88)
Not achieved (recommendation repeated as a housekeeping point, 4.38)

Individual rights

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

Recommendations

Custody staff should receive further specialist training in the management of juveniles. All policies and procedures should be reviewed to ensure that they take into account the distinct needs of juveniles. (5.74)
Not achieved

Custody staff should receive training in working with female detainees. Policies and procedures should be checked to ensure they take into account the distinctive needs of women. (5.75)
Achieved

Detainees held for a day or more should be offered a pack of basic hygiene items and women routinely offered sanitary items. (5.76)
Achieved

The MPS should consult with the local authority with a view to improving availability of appropriate adults, particularly out of normal working hours. (5.77)
Partially achieved

The entry of solicitors, appropriate adults, and ICVs to the custody suite should be expedited and they should not have to wait at the front desk for long periods. (5.78)
Achieved

In addition to being notified of detainees' general right to legal advice, immigration detainees should be given information on how to get independent specialist immigration legal advice. This information should be available in common languages. (5.79)
Not achieved

Information about how to complain about treatment by police, the UKBA or contractors should be available in custody suites. (5.80)
Not achieved (recommendation repeated, 5.24)

Health care

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

Recommendations

The clinical (forensic medical examination) rooms should be clinically clean and fit for purpose. (6.33)
Achieved

Staff involved in the cleaning of forensic medical examiner (FME) rooms must be conversant with the Metropolitan Police Authority's (MPA) standard operating procedures for cleaning of FME rooms. Compliance needs to be validated by a designated officer in accordance with volume 4 of the MPA cleaning contract 'to ensure that police operations are not compromised' (volume 5, paragraph 20.20, page 41). (6.34)
Partially achieved

There should be clinical governance arrangements that include the management, training, supervision and accountability of staff. (6.35)
Achieved

There should be evidence that healthcare staff receive on-going training, supervision and support to maintain their professional registration and development. (6.36)
Partially achieved

Appropriate resuscitation equipment in a 'grab bag' or similar should be easily accessible by all staff (healthcare and custody), who should understand how to access and use it effectively. There should be documented checks of all resuscitation equipment. (6.37)
Achieved

Nicotine patches should be available for detainees held for substantial periods. (6.38)
Not achieved (recommendation repeated, 6.19)

All clinical records should be held in accordance with Caldicott guidelines. (6.39)
Partially achieved

All clinical records should be contemporaneous and conform to professional guidance from the relevant regulatory body, such as the General Medical Council. (6.40)
Partially achieved

Information sharing protocols should exist with all appropriate agencies to ensure efficient sharing of relevant health and social care information. (6.41)
Not achieved

All medications on site should be stored safely and securely and unused medication disposed of safely. (6.42)
Achieved

There should be safe pharmaceutical stock management and use. (6.43)
Achieved