



# Report on an inspection visit to police custody suites in the Metropolitan Police Service Borough of Hammersmith and Fulham

4 – 7 July 2011

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Crown copyright 2011

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

Ashley House  
Monck Street  
London SW1P 2BQ  
England

# Contents

1. Introduction	5
2. Background and key findings	7
3. Strategy	11
4. Treatment and conditions	13
5. Individual rights	19
6. Health care	23
7. Summary of recommendations	29
<b>Appendices</b>	
I Inspection team	32
II Summary of detainee questionnaires and interviews	33



# 1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates and which form a key part important 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<sup>1</sup>. The inspections look at strategy, treatment and conditions, individual rights and health care.

This unannounced inspection looked at the custody suites in Fulham, Hammersmith and Shepherds Bush, serving the London Borough of Hammersmith and Fulham within the Metropolitan Police Service (MPS). Strategic oversight of the suites was provided centrally by the MPS Criminal Justice Directorate within the Territorial Policing department, which seeks to ensure consistency in custody provision across all London boroughs. The Metropolitan Police Authority (MPA) has responsibility for the estate and manages an active independent custody visitors scheme.

The strategic oversight within the borough needed improvement, with inconsistent staffing arrangements, utilising permanent staff and shift relief staff on a temporary basis. Managers were not clear if all staff used in the custody environment had been trained undertake the role. There was some good partnership working and the independent custody visitors' (ICV) scheme was working well. There was a lack of appropriate monitoring of the use of force in the custody environment.

Cells and other detainee areas were tired, with graffiti evident in cells. There were significant privacy issues when booking-in at Fulham. Interactions with detainees were generally appropriate but there was limited attention to diversity and particular vulnerabilities. Management of health and safety issues was inadequate. Some basic hygiene needs were only provided when requested and not as a matter of course. Cell inspections showed no ligature points and cell bells were responded to promptly.

An appropriate balance was maintained between progressing cases and the rights of individuals, and the Police and Criminal Evidence Act (PACE) was adhered to. Arrangements for managing DNA needed attention. Legal advice was readily available and staff were observed informing someone of the detainees arrest as requested. Telephone calls between the detainee and solicitor could not be undertaken in private. Arrangements for taking complaints were poor.

Healthcare provision was in need of improvement with delays evident in the attendance of forensic medical examiners (FME's) after request. There was a lack of effective clinical governance and medicines management arrangements were poor. Police staff made efforts to collect medications from detainees' home addresses. Resuscitation equipment was available to staff who were trained in its use. Substance misuse services were good. There were no mental health in-reach services but effective arrangements for section 136 patients with the local NHS hospital.

Overall, custody provision in Hammersmith and Fulham was disappointing and needed improvement. This report sets out a number of recommendations that we hope will assist the

---

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

MPS and MPA to improve provision within the borough. 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.

**Sir Denis O'Connor**  
HM Chief Inspector of Constabulary

**Nick Hardwick**  
HM Chief Inspector of Prisons

September 2011

## 2. Background and key findings

- 2.1 The Metropolitan Police Service (MPS) operates 53 custody suites, 24 hours a day, to deal with the majority of detainees arrested during normal daily policing. A further 20 are reserved as 'overflow custody suites' and are used for various operational purposes. These include: charging centres for football matches, a fallback when maintenance work requires closure of another 24-hour suite, other operational demands over and above custody core business and Operation Safeguard (overflow from prisons), when activated. In total, the MPS has 74 custody suites designated under PACE for the reception of detainees.
- 2.2 This unannounced inspection was conducted at police custody suites in the London Borough of Hammersmith and Fulham. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites. Hammersmith custody suite had 18 cells and Fulham nine and both suites were open 24 hours a day. We also visited Shepherds Bush, which had nine cells and was used as an overflow custody suite. Hammersmith had received 5,289 detainees in the year to May 2011, Fulham 3,073 and Shepherds Bush 136. In the same period, 129 immigration detainees had been held at the boroughs custody suites.
- 2.3 A survey of prisoners at HMP Wormwood Scrubs who had formerly been detained in the suites was conducted by an HM Inspectorate of Prisons researcher and inspector (see Appendix II).<sup>2</sup>
- 2.4 Comments in this report refer to all suites, unless specifically stated otherwise.

### Strategic overview

---

- 2.5 The MPS Criminal Justice Directorate, within territorial policing team, had strategic oversight of custody in all boroughs in London. The Metropolitan Police Authority (MPA) had responsibility for the custody estate. The independent custody visitors (ICV) scheme was active and the borough was responsive to it. Partnership arrangements were reasonably well developed.
- 2.6 Strategic oversight of custody within the borough needed improvement. Staffing was a mixture of permanent and temporary shift relief staff and was unsatisfactory. Managers were not clear if all staff had been trained. Dip sampling of custody records was taking place.

---

<sup>2</sup> **Inspection methodology:** There are five key sources of evidence for inspection: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections, we use a mixed-method approach to data gathering, applying both qualitative and quantitative methodologies. All findings and judgements are triangulated, which increases the validity of the data gathered. Survey results show the collective response (in percentages) from detainees in the establishment being inspected compared with the collective response (in percentages) from respondents in all establishments of that type (the comparator figure). Where references to comparisons between these two sets of figures are made in the report, these relate to statistically significant differences only. Statistical significance is a way of estimating the likelihood that a difference between two samples indicates a real difference between the populations from which the samples are taken, rather than being due to chance. If a result is very unlikely to have arisen by chance, we say it is 'statistically significant'. The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance. (Adapted from Towel et al (eds), *Dictionary of Forensic Psychology*.)

## Treatment and conditions

---

- 2.7 Staff interactions with detainees were generally respectful, although there were exceptions to this. Awareness of diversity issues was mixed. There were significant privacy issues at Fulham. Professional interpreting services were used when needed.
- 2.8 Risk assessments were carried out when detainees arrived in custody and these were generally thorough and risk management appropriate. Handovers between shifts took place but needed to be improved. We had concerns about the lack of control of cell keys. Cells and other detainee areas were tired and some cells were dirty, although there were no ligature points. Health and safety walk-through arrangements were inadequate. Detainees were told how to use cell call bells and these were responded to promptly.
- 2.9 Detainees were provided with mattresses, pillows and blankets but some of these were worn. Showers were rarely facilitated. Toilets in cells covered by CCTV were obscured but detainees had to request toilet paper. In some cases, detainees were given paper suits when their clothes were removed. Adequate food and drinks were provided. Reading materials were limited and outside exercise rarely facilitated.
- 2.10 There was limited governance of use of force.

## Individual rights

---

- 2.11 We found a positive approach to balancing the priorities of progressing cases with the rights of individuals but there was little focus on alternatives to custody. Detainees were offered a copy of PACE. We saw no breaches of PACE. The management of DNA and forensics needed attention.
- 2.12 Legal assistance was offered. Staff made calls to notify someone of the detainee's arrest but initial telephone calls to solicitors could not be undertaken in private. Children were not held in custody under section 46 of the Children Act 1989.
- 2.13 We were told that immigration detainees were usually moved on quickly. Detainees were routinely asked if they had any dependency obligations. Pre-release risk assessments were completed but the quality varied.
- 2.14 Relatives or friends were usually called on to act as appropriate adults (AAs) for juveniles and vulnerable adult detainees. When this was not possible, there were reasonable options available to provide an AA during the day but not out of hours.
- 2.15 Cut-off times for court were adequate. Detainees were not routinely told how to make a complaint and the arrangements for taking complaints were poor.

## Health care

---

- 2.16 Primary health services were in need of improvement and there were too many delays in the arrival of forensic medical examiners (FMEs) once called. Clinical governance arrangements for FMEs needed improvement.



- 2.17 Medicines management arrangements were poor and medical rooms dirty and poorly equipped. Police staff made efforts to collect medications from detainees' home addresses. Resuscitation equipment was available to custody staff who were trained in its use. There was no consistency for detainees who were on a programme of supervised consumption of methadone but symptomatic relief to detainees who required it was available. Substance misuse services were good and detainees who were primary problem alcohol were provided for. There were no mental health diversion services provided but no detainees were held under section 136 of the Mental Health Act 1983.<sup>3</sup>

## Main recommendations

---

- 2.18 The borough should ensure that staff working in custody fully understand their role and are adequately trained to carry out their duties.
- 2.19 Cells should be clean and kept free of graffiti.
- 2.20 Dispensed medications for administration by custody staff should be kept in individual detainee lockers. Medicines management should be in accordance with national and professional guidance and be subject to regular audit.
- 2.21 There should be a mental health diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services.

---

<sup>3</sup> Section 136 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.



## 3. Strategy

### Expected outcomes:

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

- 3.1 The MPS has a Criminal Justice Directorate, within Territorial Policing, headed by a Commander. A chief superintendent is responsible for day-to-day management. The Criminal Justice Directorate has an internal inspection function for audit and compliance, health and safety and the implementation of SDHP guidance. The inspection function has mechanisms to ensure compliance with inspection findings. The Criminal Justice Commander sat on the programme board for SDHP and was clearly focused on ensuring an emphasis on 'professionalising custody'.
- 3.2 Policies are signed off at a strategic command level within the MPS and the Criminal Justice Directorate provides standard operating procedures (SOPs) that support delivery of force policies by local custody management teams at suites in each London Borough Operational Command Unit (BOCU), of which there are 32, plus Heathrow Airport. The SOPs are constantly reviewed and updated and cover 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. The SOPs are designed to assist BOCUs to deliver consistent levels of service.
- 3.3 Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and accountability therefore rested with the Chief Superintendent Borough commander. Each borough has a lead member from the Metropolitan Police Authority (MPA) but there is no defined MPA lead for custody. However, an MPA official manages the independent custody visitors (ICV) scheme and had lead responsibility for reporting on custody issues.
- 3.4 There was a lack of oversight and consequently leadership within the borough in respect of custody issues. Responsibility for custody was delegated to the criminal justice unit lead, who was a chief inspector. He met monthly with the borough commander to discuss criminal justice issues. The MPS Criminal Justice Directorate had inspected the custody suites at Hammersmith and Fulham in November 2010 and made a number of recommendations but there had been disappointingly little progress in addressing these.
- 3.5 The suite at Hammersmith was staffed by permanent custody sergeants and designated detention officers (DDOs), although a shortage of DDOs meant police constable (PC) gaolers were also used. When required, sergeants from operational patrol teams were posted in to cover, sometimes for just a day at a time. Permanent custody staff worked 12-hour shifts but there were changes of staff within the shifts when cover was provided by operational patrol teams, which increased the number of handovers and introduced unnecessary risk. The suite at Fulham was staffed by sergeants from operational patrol teams supported by PC gaolers. There were no DDOs. When used, the suite at Shepherd's Bush was staffed by sergeants and PC gaolers from operational patrol teams. The wide use of temporary staff was of concern and may have been a contributory factor in issues we raise around consistency, care and welfare. (see main recommendation 2.18).
- 3.6 An inspector was the custody manager for the three suites. He also had other responsibilities and occasionally covered as duty officer for the borough. The custody manager had line

management responsibility for the permanent custody officers. When used to cover, operational patrol team staff were line managed by their respective supervisors.

- 3.7 All DDOs and custody sergeants had received nationally approved custody training but there was no system to ensure custody sergeants received refresher training and the custody manager did not keep training records. PC gaolers were required to complete a computer-based training package before working in custody but the quality assurance of this and the system for ensuring that only trained PCs were used was neither robust nor clear.
- 3.8 Partnership arrangements were described as good, with engagement with relevant criminal justice and health partners. There was an integrated prosecution team, allowing Crown Prosecution Service (CPS) and borough staff to work together in the same premises. The CPS held a fortnightly charging surgery when officers could discuss more complicated cases with lawyers. The borough commander met monthly with the CPS borough lead and the criminal justice unit chief inspector attended a bi-monthly borough criminal justice partnership group and a court user group.
- 3.9 The ICV scheme was viewed by all parties as an important independent oversight mechanism. ICVs visited the custody suites regularly and were focused on detainee welfare. They prepared a feedback report after each visit and quarterly summary reports for ICV panel meetings. Concerns identified by ICVs were addressed either immediately by the custody sergeant or longer-term by the custody manager. ICVs stated that they had good relationships with custody staff. The custody manager attended the quarterly panel meetings.
- 3.10 Only limited custody-specific meetings were held and there was no formal forum where custody practitioners and managers could share information. The criminal justice unit chief inspector attended criminal justice manager meetings hosted every six months by the MPS Criminal Justice Directorate. Minutes of these meetings were circulated to custody staff.
- 3.11 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating successful interventions and Independent Police Complaints Commission (IPCC) publications. The newsletters were emailed to custody-trained staff but not all custody sergeants were aware of the IPCC 'Lessons Learned' briefings, which were not available on the intranet. The custody manager shared any immediate learning from successful intervention reports with custody staff but there was too much reliance on email to communicate with staff, especially at Fulham.
- 3.12 We found evidence of quality assurance checks by the custody manager, who was required to dip sample custody records. The checks did not follow a set checklist, nor were they formally recorded, however, we found the quality of custody records were of a reasonable standard. CCTV was not routinely dip sampled.

## Housekeeping point

---

- 3.13 The borough should consider building a borough custody webpage on the force intranet with links to relevant newsletters and other custody information, including the IPCC 'Lessons Learned' briefings, and staff encouraged to use it.

## 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 Vehicles used to transport detainees to custody were in a satisfactory condition. Not all detainees arrived in handcuffs and most of those who did had them removed before being booked in. Custody staff mainly treated detainees with respect, used first names and were friendly and professional. Detainees we spoke to were positive about staff and we witnessed several incidents when staff managed to calm a detainee's aggression and appeared to gain their trust. On one occasion, a custody sergeant spent some time with an angry detainee patiently explaining why his fingerprints and DNA had to be taken.
- 4.2 Other than being asked if they wanted to speak to a female officer, there was no specific provision for women detainees. Custody sergeants were aware of the need to offer a transgender detainee the choice of being searched by male or female staff.
- 4.3 Staff at Hammersmith said they tried to avoid putting juveniles in cells and we saw staff allowing them to sit with their families in the booking in area or a consultation room. This was not evident at Fulham, where most staff could identify little reason to treat juveniles any differently to adults. Staff could not recall having received child protection awareness training or anything that directed them how to deal with juveniles in custody. None of the cells had been adapted for detainees with disabilities. There was no hearing loop for hard of hearing detainees and no information in Braille.
- 4.4 There was less awareness among staff of ethnic diversity than might be expected in a very diverse London borough. A Qur'an and Bible were available at Fulham and Hammersmith suites but the storage of some items needed to be improved. The direction of Mecca was not identified in cells.
- 4.5 There was a fundamental lack of privacy in the booking in area at Fulham. While only one detainee could be booked in at a time, other detainees left in the area could easily listen to conversations between staff and detainees and between the various staff present. We observed staff discussing confidential information about detainees in full hearing of other detainees and a police officer having a personal telephone conversation in full hearing of a detainee he had arrested.

### Recommendations

---

- 4.6 There should be a clearer focus on ensuring that the needs of all detainees are addressed, including juveniles, women, those with disabilities and members of ethnic minorities.
- 4.7 The booking in area at Fulham should be effectively managed to ensure confidentiality is maintained and staff should not make personal calls in the area.

## Housekeeping point

---

- 4.8 Items used for with religious observance should be stored respectfully and the direction of Mecca should be identified in cells.

## Safety

---

- 4.9 Risk assessments of detainees on arrival were satisfactory and custody sergeants asked more detailed questions when a detainee disclosed any self-harm issues. The interviews did not always take place in private, particularly at Fulham where space was limited and detainees were often expected to answer personal questions in the hearing of others (see above). There was a risk that they might not disclose all relevant information that could impact on the final risk assessment. Some detainees who were not assessed as at risk of self-harm were allowed to keep items such as glasses. Observation levels used were proportionate.
- 4.10 Police National Computer (PNC) warning markers about previously identified risks were automatically flagged by the NSPIS custody system and custody sergeants knew how to add new markers when necessary.
- 4.11 Staff were clear about rousing detainees thought to be under the influence of drink or drugs and a reminder was prominently displayed on cell doors at Fulham. Staff carried ligature knives with the cell keys but these were not suitable for use with larger ligatures. Additional cutters for thick ligatures were available behind the custody desk. In our cell surveys, we found no ligature points evident.
- 4.12 Shift handover arrangements were mixed, with no set process followed. Sergeants and DDOs had separate handovers, which risked information being missed, and we saw them taking place at Fulham when there was a great deal of activity in the suite that could easily have been distracting. It was positive that incoming sergeants routinely visited each detainee to introduce themselves.
- 4.13 The CCTV system at Hammersmith was outdated and staff said it was unreliable. One monitor displayed nine images simultaneously so they were too small to show a clear picture. The monitor was also sited in a way that meant detainees had a clearer view of it than staff.

## Recommendations

---

- 4.14 **Shift handovers should take place jointly between the outgoing and incoming shifts and include DDOs. The custody area should be cleared during the handover period.**
- 4.15 **The CCTV system should be updated and should not be visible to detainees.**

## Use of force

---

- 4.16 Use of force in 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. This meant that there was no management information accessible from a local or force-wide perspective. We were assured that force was generally used as a last resort and staff said they would call an FME when necessary for a detainee who had been subject to it.

## Recommendation

---

- 4.17 The Metropolitan Police Service should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

## Physical conditions

---

- 4.18 The Fulham suite was run down and grubby, with ingrained dirt on the floors, walls and around the toilets. The bed plinths had recently been re-varnished and had not been allowed to dry properly before the mattresses had been put back, which had led to them being stuck. Hammersmith was better but there was graffiti on bed plinths and around the doors (see main recommendation 2.19).
- 4.19 Custody staff were expected to carry out and record daily health and safety, maintenance and cleanliness checks of their facilities. However, these were not undertaken daily and the records at Fulham contained gaps as long as a month between checks. They were not sufficiently rigorous and the custody sergeants did not appear to undertake any quality assurance of them. The custody manager conducted weekly, monthly, quarterly and annual checks and the records of these were overseen by the criminal justice unit chief inspector. These checks were less frequent at Fulham, while Shepherds Bush was checked only before it was used even though there was little day-to-day supervision of the suite (see also section on health care). For example, we found police staff using the suite at Shepherds Bush as a convenient 'writing area' on the day we visited; it was also very messy. Given the very low throughput of detainees at the suite and the additional risks evident, it was not clear why the suite was still in use. When we visited Fulham at 10.30pm, we found one juvenile being held in darkness because the nightlight in his cell had failed and this had not been picked up by a cell check. He was later moved. In our survey, only 29% of detainees, significantly worse than the comparator, said the cell lighting was good.
- 4.20 Staff said fire drills were held but the record of these at Fulham contained only the policy. The no smoking policy appeared to be enforced.
- 4.21 Detainees said staff had explained the use of the call bells and we saw these responded to promptly. However, it appeared that any police officer in the suite at the time would respond to call bells and take cell keys with them, circumventing custody staff supervision of detainees. We also saw non-custodial staff being given the keys to visit detainees in cells without a good reason being provided and observed the keys left unattended on the Fulham booking in desk. We were not convinced that DDOs or PC gaoles always ensured an accurate entry was made on the custody record when this happened.

## Recommendations

---

- 4.22 The borough should ensure regular health and safety checks are carried out to a common standard.
- 4.23 The borough should review the use and management of Shepherds Bush custody suite.
- 4.24 Visits to cells should be undertaken only by custody staff or if necessary accompanied by them and custody staff should ensure that the security of cell keys and visits are not compromised.

## Personal comfort and hygiene

---

- 4.25 All cells contained mattresses and pillows. Apart from those contaminated by varnish, the mattresses were reasonably clean but all were very thin. Some, particularly at Hammersmith, were damaged and potentially hazardous. Supplies of blankets appeared sufficient.
- 4.26 Staff said women detainees could ask for hygiene packs and a poster advertising this was displayed. However, there were only three packs at Fulham and not all contained sanitary pads. Detainees at Fulham were given packs of toilet paper but those at Hammersmith had to ask for a few sheets at a time. CCTV coverage of toilet areas was obscured but this was not routinely explained to detainees. In some cells, the image of the toilet reflected in the ceiling mirrors had not been obscured.
- 4.27 None of the respondents to our survey said they had been offered a shower. We were told that detainees could have a shower but staff at Fulham said few did so and the location and door on the only shower at Hammersmith allowed little privacy, particularly for female detainees, and it was in any case being used to store several mop buckets. If a shower was facilitated, only paper towels were provided.
- 4.28 The stock of track suit bottoms and T-shirts at Fulham was inadequate and staff said they encouraged detainees' families to bring in replacement clothing when required. The stock at Hammersmith was better but neither suite offered replacement underwear. Several detainees, particularly at Fulham, were wearing paper suits but staff said no one was ever released in one.

## Recommendations

---

- 4.29 Damaged mattresses should be replaced.
- 4.30 Detainees who need a shower should be able to take one in reasonable privacy and should be provided with a cotton towel.
- 4.31 Adequate replacement clothing should be provided and underwear should be available.

## Housekeeping points

---

- 4.32 Toilet paper should be available in all cells.
- 4.33 Detainees should be told that the toilet area is obscured on the CCTV coverage.

## Catering

---

- 4.34 The police station canteens supplied detainees' meals during office hours. Microwave meals were available at other times and some were Halal but none appeared to be Kosher. The temperature of microwave meals was not tested at the point of serving. Staff offered detainees hot and cold drinks at regular intervals. We were told that food handling was included in custody staff training.



## Housekeeping point

---

- 4.35 Meals that are suitable for a range of dietary requirements should be provided.

## Activities

---

- 4.36 Neither suite had facilities for outdoor exercise and neither provided reading material other than a few magazines in English. There was no provision for visits, although a consultation room at Hammersmith was occasionally made available for parents to visit juveniles.

## Recommendations

---

- 4.37 Provision should be made for detainees, particularly those held over 24 hours, to be offered exercise.
- 4.38 A suitable range of reading material should be provided, including for young people and those who cannot read English.



# 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 checked that detention was appropriate before authorising it. Although alternatives to custody, such as voluntary attendance, were readily available, we were told that officers preferred to arrest and process the suspect through the custody suite.
- 5.2 Staff said the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989<sup>4</sup>.
- 5.3 Detainees' rights and entitlements were explained to them on arrival and most were given a pamphlet summarising these. Custody sergeants downloaded and printed information for non-English speaking detainees about their rights in their own languages. A professional telephone interpreting service was readily available and we were informed that there was a good face-to-face interpreter service.
- 5.4 The relationship with the UK Border Agency (UKBA) was described as good, with most immigration detainees held no longer than 24 hours.
- 5.5 Detainees were routinely asked if they had dependants at home. We observed detainees making telephone calls to a solicitor but these were made at the booking-in desk rather than in private. Those who declined a solicitor were told they could change that decision later.
- 5.6 Reviews of detainees while they were in custody were undertaken by a police inspector and our observations and analysis of custody records confirmed that these generally took place on time and in person.
- 5.7 A pre-release risk assessment list of questions in the NSPIS custody system was used for all detainees before their release.

### Recommendations

---

- 5.8 **Police officers should be encouraged to make more use of alternative to custody processes where appropriate, such as voluntary attendance at the police station.**
- 5.9 **Detainees should be able to speak privately to a solicitor on the telephone.**

---

<sup>4</sup> Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

## Rights relating to PACE

---

- 5.10 Solicitors described a good culture in the custody suites and did not report any major issues regarding detainees' rights. They did not report any problems in obtaining copies of custody records. In our survey, 83% of respondents, higher than the comparator, said they had been interviewed with a solicitor present. It was not always clear that detainees who chose not to speak to a solicitor had been asked the reason why. Most detainees received the services of a solicitor promptly but our custody record analysis revealed that one detainee had been held for almost a day without receiving legal advice even though this had been requested. The reasons for this were unclear but it is likely that this detainee would not have been interviewed as he had been arrested for a prison recall. Nevertheless, legal advice could have been given in these circumstances. The PACE codes of practice booklet was readily available but seldom requested.
- 5.11 Detainees were not interviewed when intoxicated or under the influence of drugs.
- 5.12 Appropriate adults for juvenile detainees could be obtained reasonably easily during office hours through the local youth offending service. Outside these hours, a volunteer scheme operated for both juvenile and vulnerable adult detainees. Staff said this met most of the demand but when necessary there was also the option of contacting The Appropriate Adult Service (TASS), a local authority-funded scheme. The force adhered to the PACE definition of a child (as a person under 17) instead of the Children Act definition, which meant those aged 17 were not given an appropriate adult unless they were otherwise deemed to be vulnerable<sup>5</sup>.
- 5.13 There were some local authority non-secure beds for juveniles in the borough but these were rarely used as custody staff did not appear to be aware of them. Custody was not being used under section 46 of the Children Act (1989) as a place of safety<sup>6</sup>.
- 5.14 Court cut-off times were adequate and custody officers were usually able to get detainees into the magistrates' court until about 3pm on weekdays and at least 10am on Saturday.
- 5.15 The management of DNA and freezers within custody was ineffective and needed to be addressed. The freezer at Fulham contained DNA samples which were several weeks old and at Shepherd's Bush, inspectors found numerous DNA samples, some of which were almost a year old. Registers for recording samples in and out were incomplete, thereby compromising the continuity and integrity of these samples. These issues present a significant organisational risk.

## Recommendation

---

- 5.16 **There should be effective management and oversight in the handling and submission of DNA samples taken in custody to ensure they are submitted for analysis without delay.**

---

<sup>5</sup> Although this met the current requirements of PACE, in all other UK law 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.

<sup>6</sup> Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

## Housekeeping point

---

- 5.17 Custody officers should routinely ask all detainees who decline the services of a solicitor the reason why they are doing so and record the response on the custody record.

## Rights relating to treatment

---

- 5.18 The borough commander had a clear expectation that complaints should be taken while detainees were still in custody but this did not happen in practice and staff said complaints were usually taken once detainees had been released. There was no procedure to take complaints from detainees who were taken to court and remanded in custody and therefore not released from police custody. Detainees were not told how to make a complaint and there was no information about the procedure on display.

## Recommendation

---

- 5.19 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance<sup>7</sup> and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody.

---

<sup>7</sup> IPCC statutory guidance (2010)



## 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 Health care was provided by forensic medical examiners (FMEs) employed by the MPS. Mental health services were provided by West London Mental Health NHS Trust (WLMHT) and substance use services by Turning Point, an independent sector provider. There were no contract performance indicators for the FME service. Police inspectors managed the strategic approach to mental health and substance misuse services and monitored the substance use services contract.
- 6.2 Clinical and substance use staff treated detainees with respect and had access to interpreting services if required. Female detainees were not always able to see a female FME, in which case female officers acted as chaperones. In our survey, only 24% of detainees seen by a health professional said the quality of care was good or very good, although detainees we spoke to did not mention any issues about health care and there had been no complaints about it in the previous 12 months.
- 6.3 Clinical governance arrangements for FMEs were not clear and custody officers did not appear to know how FME credentials were checked or how they received mandatory training or continuing professional development. One FME assured us that he received appropriate training from the Faculty of Forensic and Legal Medicine. Not all FMEs were approved clinicians under Section 12 of the Mental Health Act.
- 6.4 All suites had clinical rooms labelled 'surgeon's room'. Those at Fulham and Shepherds Bush were small. Doors were closed during consultations allowing detainees privacy and confidentiality but not all rooms had privacy screens. There was no evidence that an infection control audit had been carried out and none of the rooms met expected standards. Examination couches were torn and fixtures and fittings were worn, tarnished or badly chipped. The rooms at Hammersmith and Fulham were superficially clean but all were grubby with ingrained dirt and were in need of a deep clean. The room at Shepherds Bush was visibly dirty and had not been cleaned for some considerable time. Daily checks were undertaken at Fulham but there was otherwise no schedule or record of daily cleaning.
- 6.5 The clinical rooms contained medical equipment and out-of-date supplies. Overall stock control appeared haphazard and the contents of several cupboards was disorganised. Sharps bins were not secured to the wall or signed and dated when first used and those at Shepherds Bush were filled above the recommended line and therefore unsafe. Rooms were not used by custody staff and, apart from at Shepherds Bush, all were locked when not in use. We did not see any patient information leaflets and there were no health screening or promotion materials on display. Written clinical guidelines for FMEs were very out of date.
- 6.6 Medicines management was poor. A significant amount of stock was out of date and the medicine cupboard at Shepherds Bush was unlocked. Medicines cupboards contained loose blister packs, tablets and medications belonging to former detainees. FMEs were able to supply and administer a range of medications and dispense medications to be given at a later

date by custody staff. Custody staff administered medications only when they were prescribed and dispensed by a doctor. At Fulham, ongoing doses of prescribed medications were stored in sealed and labelled bags that were attached to clipboards behind the booking-in desk in public view. The dispensing of the scheduled drugs diazepam (a sedative) and dihydrocodeine (an analgesic) was recorded in a register that was not designed for this purpose. From the register, it was not possible to check stock levels against medications dispensed and there were no regular audits or stock balance data available for checking. We were concerned by what we saw and informed the primary care trust accountable officer. Refrigerators used to store thermolabile products (requiring refrigeration) did not have temperature sensors or records of checks. Wound glue stored in the refrigerators was out of date (see main recommendation 2.20).

- 6.7 Custody staff tried to retrieve prescribed medications from detainees' homes if necessary. There was no consistency for detainees who were on a programme of supervised consumption of methadone. Custody staff said detainees could not take methadone in custody but the MPS policy indicated that it should be available. An FME at Fulham said detainees were given methadone in custody when an FME was present but the inability to guarantee access to an FME at specific times meant equality of access to methadone could not be assured. Symptomatic relief was prescribed for those withdrawing from substances.
- 6.8 Emergency equipment was available at Fulham and Hammersmith and included a first aid kit, limited resuscitation equipment and automated external defibrillators, which were easily accessible. The kit was regularly checked but grubby. Custody staff we spoke to were up to date with their first aid and resuscitation training. Eye wash fluid was out of date in the clinical rooms and we saw open bottles of used eye wash fluid in the cupboards at Hammersmith.

## Recommendations

---

- 6.9 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.
- 6.10 There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and capable of being used to take forensic samples.
- 6.11 If it is clinically indicated, methadone should be available to detainees in line with national guidelines.
- 6.12 Custody staff should have access to a full range of clean and easily accessible first aid and resuscitation equipment.

## Housekeeping points

---

- 6.13 Detainees should be able to see a female health professional on request.
- 6.14 Privacy screens should be provided in the consultation rooms.
- 6.15 Out-of-date clinical reference materials should be discarded and replaced by up-to-date materials.



- 6.16 All used and out-of-date clinical stock and medical stock should be disposed of and regular checks of expiry dates instigated.
- 6.17 Patient information leaflets should be accessible in the clinical rooms.
- 6.18 Out-of-date pharmacological reference materials should be discarded and replaced by up to date materials.
- 6.19 The refrigerators used to store thermolabile clinical products in the clinical rooms should have the maximum and minimum temperatures recorded daily to ensure that thermolabile items are stored within the 2- 8°C range.

## Patient care

---

- 6.20 FMEs were available on a rota that was displayed electronically at the booking-in desks. There was a 24-hour service, with FMEs undertaking shifts and covering adjacent police boroughs in addition to Fulham and Hammersmith. There were occasional gaps in the rotas.
- 6.21 New arrivals were asked if they wanted to see a health care professional and custody officers referred them to one if they presented any health-related concerns. Custody records indicated that 20% of detainees were seen by a FME. Custody staff rang the FME on call to request assistance and the call out and response times were entered on the custody record. In a sample of 30 custody records, the average response time was two hours 23 minutes, with the longest over four hours. There appeared to be no central monitoring of this. Custody staff said delays were understandable but getting worse. We were told that FMEs' coverage of adjacent boroughs delayed the response times and that traffic congestion was another factor. One custody sergeant said a FME had asked custody staff to pose clinical questions to detainees before making a decision to respond, which was inappropriate. In a number of cases, the detainee had been released before the FME had arrived, several hours after referral. One was a detainee who had undergone recent back surgery and said she was pregnant and who custody staff thought may have experienced a whip lash injury. Another was a detainee who was thought to have glass embedded in her foot.
- 6.22 FMEs used paper records to record consultations and contributed to the NSPIS custody records. One FME said he stored clinical records at home. There was no auditing of clinical records and it was unclear how the MPS could assure itself that all clinical records were stored in line with data protection requirements and Caldicott principles<sup>8</sup>.

## Recommendations

---

- 6.23 Forensic medical examiners should be available to respond promptly to requests from custody officers.
- 6.24 All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information.

---

<sup>8</sup> The Caldicott review (1997) stipulated certain principles and working practices that health care providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

## Housekeeping point

---

- 6.25 The referral, attendance and contact times of FMEs should be recorded, subjected to audit and the data used to improve detainees' access to health care.

## Substance use

---

- 6.26 In our survey, 47% of respondents said they had a drug or alcohol problem and analysis of custody records indicated that 27% of detainees were said to be intoxicated on arrival in custody. In our survey, 76% against a comparator of 42% said they had been offered an opportunity to see a drug worker. There were good multi-agency working arrangements to ensure that substance users could readily access relevant services.
- 6.27 Turning Point staff provided an intensive drug intervention programmes from 7.30am to 10.30pm six days a week. Drug workers visited Hammersmith daily or more frequently in busy periods. They attended Fulham following a telephone request from custody staff. As well as seeing those who tested positive for drugs, they visited every cell to ask detainees if they wanted assistance. Out-of-hours, custody staff telephoned the Hammersmith and Fulham druglink helpline to make appointments for detainees. A special drugs court on Tuesdays provided an opportunity for diversion from custody. Substance use services were offered to adults aged 18 or over. In our survey, 44% of detainees with drug and alcohol problems said they required symptomatic relief while in custody. Detainees with alcohol-related problems were offered support and access to Turning Point community programmes. Juveniles were signposted to services for young people. Substance users were offered an extensive range of programmes following release and detainees who needed it were signposted to needle exchange services in the community.

## Mental health

---

- 6.28 In our survey, 12% of detainees said they had mental health problems. Mental health services were provided by WLMHT and partnership working was generally described as good but the Trust had cancelled two out of three recent liaison group meetings. There were no mental health in-reach services but custody officers said the local crisis resolution teams responded to telephone referrals. There were several joint operational policies and protocols for mental health working including an information-sharing protocol and a multi-agency risk assessment conference (MARAC) protocol. The emergency duty team (EDT) provided Mental Health Act assessments and was said to be responsive, although there were delays out of hours. We observed the team in action at Fulham and their communications with the detainee and custody sergeant were particularly good. EDT members suggested they received referrals from the police three or four times a week (see main recommendation 2.21).
- 6.29 There was a revised draft Section 136 agreement and guidance for the police. The NHS Section 136 suite was at the new Charing Cross Hospital. Relatively small numbers of Section 136 detainees were coming into police custody, with only nine in the year to the end of April 2011. Health service staff said most detainees taken to the Section 136 suite were subsequently detained under the Mental Health Act, which suggested that the police were using Section 136 appropriately.
- 6.30 There was no regular mental health training for custody staff subsequent to induction, although some self-guided learning materials were available.

## Recommendation

---

- 6.31 Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems and work effectively with health staff to ensure a detainee's care.



## 7. Summary of recommendations

<b>Main recommendations</b>	<b>To the Metropolitan Police Service</b>
-----------------------------	---

---

- 7.1 The borough should ensure that staff working in custody fully understand their role and are adequately trained to carry out their duties. (2.18)
- 7.2 Cells should be clean and kept free of graffiti. (2.19)
- 7.3 Dispensed medications for administration by custody staff should be kept in individual detainee lockers. Medicines management should be in accordance with national and professional guidance and be subject to regular audit. (2.20)
- 7.4 There should be a mental health diversion scheme that enables detainees with mental health problems to be identified and diverted expeditiously into appropriate mental health services. (2.21)

<b>Recommendations</b>	<b>To the Metropolitan Police Service</b>
------------------------	---

---

### **Treatment and conditions**

---

- 7.5 There should be a clearer focus on ensuring that the needs of all detainees are addressed, including juveniles, women, those with disabilities and members of ethnic minorities. (4.6)
- 7.6 The booking in area at Fulham should be effectively managed to ensure confidentiality is maintained and staff should not make personal calls in the area. (4.7)
- 7.7 Shift handovers should take place jointly between the outgoing and incoming shifts and include DDOs. The custody area should be cleared during the handover period. (4.14)
- 7.8 The CCTV system should be updated and should not be visible to detainees. (4.15)
- 7.9 The Metropolitan Police Service should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.17)
- 7.10 The borough should ensure regular health and safety checks are carried out to a common standard. (4.22)
- 7.11 The borough should review the use and management of Shepherds Bush custody suite. (4.23)
- 7.12 Visits to cells should be undertaken only by custody staff or if necessary accompanied by them and custody staff should ensure that the security of cell keys and visits are not compromised. (4.24)
- 7.13 Damaged mattresses should be replaced. (4.29)
- 7.14 Detainees who need a shower should be able to take one in reasonable privacy and should be provided with a cotton towel. (4.30)

- 7.15 Adequate replacement clothing should be provided and underwear should be available. (4.31)
- 7.16 Provision should be made for detainees, particularly those held over 24 hours, to be offered exercise. (4.37)
- 7.17 A suitable range of reading material should be provided, including for young people and those who cannot read English. (4.38)

### **Individual rights**

---

- 7.18 Police officers should be encouraged to make more use of alternative to custody processes where appropriate, such as voluntary attendance at the police station. (5.8)
- 7.19 Detainees should be able to speak privately to a solicitor on the telephone. (5.9)
- 7.20 There should be effective management and oversight in the handling and submission of DNA samples taken in custody to ensure they are submitted for analysis without delay. (5.16)
- 7.21 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance<sup>9</sup> and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.19)

### **Health care**

---

- 7.22 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. (6.9)
- 7.23 There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and capable of being used to take forensic samples. (6.10)
- 7.24 If it is clinically indicated, methadone should be available to detainees in line with national guidelines. (6.11)
- 7.25 Custody staff should have access to a full range of clean and easily accessible first aid and resuscitation equipment. (6.12)
- 7.26 Forensic medical examiners should be available to respond promptly to requests from custody officers. (6.23)
- 7.27 All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information. (6.24)
- 7.28 Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems and work effectively with health staff to ensure a detainee's care. (6.31)

---

<sup>9</sup> IPCC statutory guidance (2010)

## Housekeeping points

---

### Strategy

---

- 7.29 The borough should consider building a borough custody webpage on the force intranet with links to relevant newsletters and other custody information, including the IPCC 'Lessons Learned' briefings, and staff encouraged to use it. (3.13)

### Treatment and conditions

---

- 7.30 Items used for with religious observance should be stored respectfully and the direction of Mecca should be identified in cells. (4.8)
- 7.31 Toilet paper should be available in all cells. (4.32)
- 7.32 Detainees should be told that the toilet area is obscured on the CCTV coverage. (4.33)
- 7.33 Meals that are suitable for a range of dietary requirements should be provided. (4.35)

### Individual rights

---

- 7.34 Custody officers should routinely ask all detainees who decline the services of a solicitor the reason why they are doing so and record the response on the custody record. (5.17)

### Health care

---

- 7.35 Detainees should be able to see a female health professional on request. (6.13)
- 7.36 Privacy screens should be provided in the consultation rooms. (6.14)
- 7.37 Out-of-date clinical reference materials should be discarded and replaced by up-to-date materials. (6.15)
- 7.38 All used and out-of-date clinical stock and medical stock should be disposed of and regular checks of expiry dates instigated. (6.16)
- 7.39 Patient information leaflets should be accessible in the clinical rooms. (6.17)
- 7.40 Out-of-date pharmacological reference materials should be discarded and replaced by up to date materials. (6.18)
- 7.41 The refrigerators used to store thermolabile clinical products in the clinical rooms should have the maximum and minimum temperatures recorded daily to ensure that thermolabile items are stored within the 2- 8°C range. (6.19)
- 7.42 The referral, attendance and contact times of FMEs should be recorded, subjected to audit and the data used to improve detainees' access to health care. (6.25)

## Appendix I: Inspection team

---

Sean Sullivan	HMIP team leader
Paddy Craig	HMIC inspector
Mark Ewan	HMIC inspector
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Paul Tarbuck	HMIP health care inspector
Roger James	CQC inspector
Laura Nettleingham	HMIP senior researcher



## Appendix II: Summary of detainee questionnaires and interviews

---

### **Detainee survey methodology**

---

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Hammersmith and Fulham, 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 15 – 16 June 2011. A list of potential respondents to have passed through Hammersmith, Fulham or Shepherd's Bush police stations was created, listing all those who had arrived from West London Magistrates' Court within the past two months.

### **Selecting the sample**

---

On the day, the questionnaire was offered to 24 respondents. There was one refusal and four non-returns. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. No respondents were interviewed.

### **Methodology**

---

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

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

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

### **Response rates**

---

In total, 19 (79%) respondents completed and returned their questionnaires.

### **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 41 police areas since April 2008.

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

## **Summary**

---

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

No questions have been filtered within the summary so all percentages refer to responses from the entire sample. The percentages to certain responses within the summary, for example 'Not held over night' options across questions, may differ slightly. This is due to different response rates across questions, meaning that the percentages have been calculated out of different totals (all missing data 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 have been weighted for comparison purposes.

# Survey results

## Section 1: About you

Q2	<b>What police station were you last held at?</b> Hammersmith - 13; Fulham - 5; Shepherd's Bush - 1.		
Q3	<b>How old are you?</b>		
	16 years or younger .....	0 (0%)	40-49 years .....
	17-21 years .....	0 (0%)	50-59 years .....
	22-29 years .....	9 (47%)	60 years or older .....
	30-39 years .....	9 (47%)	
Q4	<b>Are you:</b>		
	Male .....	19 (100%)	
	Female .....	0 (0%)	
	Transgender/transsexual .....	0 (0%)	
Q5	<b>What is your ethnic origin?</b>		
	White - British .....	11 (58%)	
	White - Irish .....	0 (0%)	
	White - other .....	1 (5%)	
	Black or black British - Caribbean .....	3 (16%)	
	Black or black British - African .....	1 (5%)	
	Black or black British - other .....	0 (0%)	
	Asian or Asian British - Indian .....	0 (0%)	
	Asian or Asian British - Pakistani .....	0 (0%)	
	Asian or Asian British - Bangladeshi .....	0 (0%)	
	Asian or Asian British - other .....	1 (5%)	
	Mixed heritage - white and black Caribbean .....	0 (0%)	
	Mixed heritage - white and black African .....	0 (0%)	
	Mixed heritage- white and Asian .....	0 (0%)	
	Mixed heritage - Other .....	1 (5%)	
	Chinese .....	0 (0%)	
	Other ethnic group .....	1 (5%)	
Q6	<b>Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?</b>		
	Yes .....	2 (11%)	
	No .....	16 (89%)	
Q7	<b>What, if any, would you classify as your religious group?</b>		
	None .....	2 (11%)	
	Church of England .....	7 (37%)	
	Catholic .....	5 (26%)	
	Protestant .....	0 (0%)	
	Other Christian denomination .....	1 (5%)	
	Buddhist .....	1 (5%)	
	Hindu .....	0 (0%)	
	Jewish .....	0 (0%)	
	Muslim .....	3 (16%)	
	Sikh .....	0 (0%)	

Q8	How would you describe your sexual orientation?	
	<i>Straight/heterosexual</i> .....	18 (100%)
	<i>Gay/lesbian/homosexual</i> .....	0 (0%)
	<i>Bisexual</i> .....	0 (0%)
Q9	Do you consider yourself to have a disability?	
	<i>Yes</i> .....	2 (11%)
	<i>No</i> .....	17 (89%)
Q10	Have you ever been held in police custody before?	
	<i>Yes</i> .....	17 (89%)
	<i>No</i> .....	2 (11%)

## Section 2: Your experience of this custody suite

Q11	How long were you held at the police station?			
	<i>Less than 24 hours</i> .....	3 (16%)		
	<i>More than 24 hours, but less than 48 hours (2 days)</i> .....	12 (63%)		
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i> .....	4 (21%)		
	<i>72 hours (3 days) or more</i> .....	0 (0%)		
Q12	Were you given information about your arrest and your entitlements when you arrived there?			
	<i>Yes</i> .....	15 (79%)		
	<i>No</i> .....	3 (16%)		
	<i>Don't know/can't remember</i> .....	1 (5%)		
Q13	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?			
	<i>Yes</i> .....	9 (47%)		
	<i>No</i> .....	8 (42%)		
	<i>I don't know what this is/I don't remember</i> .....	2 (11%)		
Q14	If your clothes were taken away, were you offered different clothing to wear?			
	<i>My clothes were not taken</i> .....	16 (89%)		
	<i>I was offered a tracksuit to wear</i> .....	1 (6%)		
	<i>I was offered an evidence/paper suit to wear</i> .....	1 (6%)		
	<i>I was offered a blanket</i> .....	0 (0%)		
	<i>Nothing</i> .....	0 (0%)		
Q15	Could you use a toilet when you needed to?			
	<i>Yes</i> .....	19 (100%)		
	<i>No</i> .....	0 (0%)		
	<i>Don't Know</i> .....	0 (0%)		
Q16	If you have used the toilet there, was toilet paper provided?			
	<i>Yes</i> .....	9 (53%)		
	<i>No</i> .....	8 (47%)		
Q17	Did you share a cell at the police station?			
	<i>Yes</i> .....	1 (5%)		
	<i>No</i> .....	18 (95%)		
Q18	How would you rate the condition of your cell?			
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>
	Cleanliness	7 (37%)	5 (26%)	7 (37%)

	Ventilation/air quality	3 (17%)	4 (22%)	11 (61%)		
	Temperature	2 (11%)	3 (17%)	13 (72%)		
	Lighting	5 (28%)	3 (17%)	10 (56%)		
Q19	Was there any graffiti in your cell when you arrived?					
	Yes.....			9 (50%)		
	No.....			9 (50%)		
Q20	Did staff explain to you the correct use of the cell bell?					
	Yes.....			5 (26%)		
	No.....			14 (74%)		
Q21	Were you held overnight?					
	Yes.....			19 (100%)		
	No.....			0 (0%)		
Q22	If you were held overnight, which items of clean bedding were you given?					
	<i>Not held overnight</i> .....			0 (0%)		
	<i>Pillow</i> .....			6 (32%)		
	<i>Blanket</i> .....			11 (58%)		
	<i>Nothing</i> .....			9 (47%)		
Q23	Were you offered a shower at the police station?					
	Yes.....			0 (0%)		
	No.....			19 (100%)		
Q24	Were you offered any period of outside exercise while there?					
	Yes.....			1 (6%)		
	No.....			17 (94%)		
Q25	Were you offered anything to:					
		Yes	No			
	Eat?	17 (89%)	2 (11%)			
	Drink?	16 (84%)	3 (16%)			
Q26	What was the food/drink like in the police custody suite?					
	<i>Very good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>	<i>N/A</i>
	1 (5%)	2 (11%)	1 (5%)	4 (21%)	8 (42%)	3 (16%)
Q27	Was the food/drink you received suitable for your dietary requirements?					
	<i>I did not have any food or drink</i> .....			3 (17%)		
	Yes.....			9 (50%)		
	No.....			6 (33%)		
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?					
	<i>I do not smoke</i> .....			3 (16%)		
	<i>I was allowed to smoke</i> .....			1 (5%)		
	<i>I was not offered anything to cope with not smoking</i> .....			15 (79%)		
	<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.....			3 (16%)		
	No.....			16 (84%)		

Q30	Was someone informed of your arrest?		
	Yes.....	8 (42%)	
	No.....	6 (32%)	
	I don't know.....	3 (16%)	
	I didn't want to inform anyone .....	2 (11%)	
Q31	Were you offered a free telephone call?		
	Yes.....	12 (63%)	
	No.....	7 (37%)	
Q32	If you were denied a free phone call, was a reason for this offered?		
	<i>My telephone call was not denied</i> .....	14 (82%)	
	Yes.....	1 (6%)	
	No.....	2 (12%)	
Q33	Did you have any concerns about the following, while you were in police custody?		
		<b>Yes</b>	<b>No</b>
	Who was taking care of your children	1 (8%)	11 (92%)
	Contacting your partner, relative or friend	6 (40%)	9 (60%)
	Contacting your employer	1 (9%)	10 (91%)
	Where you were going once released	4 (33%)	8 (67%)
Q34	Were you interviewed by police officials about your case?		
	Yes.....	17 (94%)	
	No.....	1 (6%)	If No, go to Q36
Q35	Were any of the following people present when you were interviewed?		
		<b>Yes</b>	<b>No</b>
	Solicitor	14 (82%)	2 (12%)
	Appropriate Adult	0 (0%)	1 (11%)
	Interpreter	0 (0%)	1 (11%)
			<b>Not needed</b>
			1 (6%)
			8 (89%)
			8 (89%)
Q36	How long did you have to wait for your solicitor?		
	<i>I did not requested a solicitor</i> .....	2 (11%)	
	2 hours or less.....	2 (11%)	
	Over 2 hours but less than 4 hours.....	3 (17%)	
	4 hours or more.....	11 (61%)	

### Section 3: Safety

Q38	Did you feel safe there?		
	Yes.....	12 (67%)	
	No.....	6 (33%)	
Q39	Had another detainee or a member of staff victimised (insulted or assaulted) you there?		
	Yes.....	9 (50%)	
	No.....	9 (50%)	
Q40	If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)		
	<i>I have not been victimised</i> .....	9 (50%)	<i>Because of your crime</i> ..... 3 (17%)
	<i>Insulting remarks (about you, your family or friends)</i> .....	4 (22%)	<i>Because of your sexuality</i> ..... 0 (0%)
	<i>Physical abuse (being hit, kicked or assaulted)</i> .....	1 (6%)	<i>Because you have a disability</i> ..... 1 (6%)

Sexual abuse.....	0 (0%)	Because of your religion/religious beliefs ..	0 (0%)
Your race or ethnic origin .....	0 (0%)	Because you are from a different part of	0 (0%)
		the country than others.....	
Drugs.....	4 (22%)		

<b>Q41</b>	<b>Were your handcuffs removed on arrival at the police station?</b>	
	Yes .....	14 (78%)
	No.....	4 (22%)
	I wasn't handcuffed.....	0 (0%)
<b>Q42</b>	<b>Were you restrained while in the police custody suite?</b>	
	Yes.....	3 (17%)
	No.....	15 (83%)
<b>Q43</b>	<b>Were you injured while in police custody, in a way that you feel was not your fault?</b>	
	Yes.....	3 (16%)
	No.....	16 (84%)
<b>Q44</b>	<b>Were you told how to make a complaint about your treatment if you needed to?</b>	
	Yes.....	3 (16%)
	No.....	16 (84%)

## Section 4: Health care

<b>Q46</b>	<b>Did you need to take any prescribed medication when you were in police custody?</b>		
	Yes.....	6 (32%)	
	No.....	13 (68%)	
<b>Q47</b>	<b>Were you able to continue taking your prescribed medication while there?</b>		
	<i>Not taking medication</i> .....	13 (68%)	
	Yes.....	2 (11%)	
	No.....	4 (21%)	
<b>Q48</b>	<b>Did someone explain your entitlements to see a health care professional if you needed to?</b>		
	Yes.....	7 (37%)	
	No.....	10 (53%)	
	Don't know .....	2 (11%)	
<b>Q49</b>	<b>Were you seen by the following health care professionals during your time there?</b>		
	<i>Yes</i>	<i>No</i>	
	Doctor	8 (50%)	8 (50%)
	Nurse	2 (15%)	11 (85%)
	Paramedic	0 (0%)	11 (100%)
	Psychiatrist	0 (0%)	11 (100%)
<b>Q50</b>	<b>Were you able to see a health care professional of your own gender?</b>		
	Yes.....	6 (32%)	
	No.....	7 (37%)	
	Don't know .....	6 (32%)	
<b>Q51</b>	<b>Did you have any drug or alcohol problems?</b>		
	Yes.....	9 (47%)	
	No.....	10 (53%)	

Q52	Did you see, or were you offered the chance to see a drug or alcohol support worker?					
	<i>I didn't have any drug/alcohol problems</i> .....					10 (53%)
	<i>Yes</i> .....					7 (37%)
	<i>No</i> .....					2 (11%)
Q53	Were you offered relief or medication for your immediate symptoms?					
	<i>I didn't have any drug/alcohol problems</i> .....					10 (53%)
	<i>Yes</i> .....					4 (21%)
	<i>No</i> .....					5 (26%)
Q54	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>
	9 (50%)	0 (0%)	2 (11%)	2 (11%)	5 (28%)	0 (0%)
Q55	Did you have any specific <u>physical</u> health care needs?					
	<i>No</i> .....					10 (56%)
	<i>Yes</i> .....					8 (44%)
Q56	Did you have any specific <u>mental</u> health care needs?					
	<i>No</i> .....					16 (89%)
	<i>Yes</i> .....					2 (11%)





## Prisoner survey responses for Hammersmith and Fulham Police 2011

Prisoner survey responses (missing data have 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

		Hammersmith and Fulham Police	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
<b>Number of completed questionnaires returned</b>		19	1483
<b>SECTION 1: General information</b>			
3	Are you under 21 years of age?	0%	9%
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)?	37%	30%
6	Are you a foreign national?	12%	14%
7	Are you Muslim?	15%	11%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	11%	20%
10	Have you been in police custody before?	89%	91%
<b>SECTION 2: Your experience of this custody suite</b>			
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?	85%	67%
12	Were you given information about your arrest and entitlements when you arrived?	79%	74%
13	Were you told about PACE?	47%	52%
14	If your clothes were taken away, were you given a tracksuit to wear?	50%	42%
15	Could you use a toilet when you needed to?	100%	90%
16	If you did use the toilet, was toilet paper provided?	53%	49%
17	Did you share a cell at the station?	6%	3%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	37%	32%
18b	Ventilation/air quality?	16%	22%
18c	Temperature?	12%	15%
18d	Lighting?	28%	43%
19	Was there any graffiti in your cell when you arrived?	50%	54%
20	Did staff explain the correct use of the cell bell?	26%	22%
21	Were you held overnight?	100%	92%
22	If you were held overnight, were you given <b>no</b> clean items of bedding?	47%	29%
23	Were you offered a shower?	0%	9%
24	Were you offered a period of outside exercise?	6%	7%
25a	Were you offered anything to eat?	89%	81%
25b	Were you offered anything to drink?	85%	84%
For those who had food:			
26a	Was the quality of the food and drink you received 'good'/very good'?	18%	9%
26b	Was the food/drink you received suitable for your dietary requirements?	60%	44%
27	For those who smoke: were you offered <b>nothing</b> to help you cope with the ban there?	93%	93%
28	Were you offered anything to read?	15%	14%
29	Was someone informed of your arrest?	42%	43%
30	Were you offered a free telephone call?	64%	50%

**Key to tables**

	Any percentage highlighted in green is significantly better	HammerSmith and Fulham Police	Police custody comparator
	Any percentage highlighted in blue is significantly worse		
	Any percentage 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?	33%	14%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	9%	14%
32b	Contacting your partner, relative or friend?	41%	53%
32c	Contacting your employer?	10%	20%
32d	Where you were going once released?	33%	31%
34	If you were interviewed were the following people present:		
34a	Solicitor	83%	72%
34b	Appropriate adult	0%	7%
34c	Interpreter	0%	7%
35	Did you wait over 4 hours for your solicitor?	69%	65%
<b>SECTION 3: Safety</b>			
39	Did you feel unsafe?	34%	39%
40	Has another detainee or a member of staff victimised you?	50%	41%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	22%	20%
41b	Physical abuse (being hit, kicked or assaulted)	6%	13%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	0%	5%
41e	Drugs	22%	14%
41f	Because of your crime	16%	16%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	6%	3%
41i	Because of your religion/religious beliefs	0%	2%
41j	Because you are from a different part of the country than others	0%	4%
42a	Were your handcuffs removed on arrival at the police station?	78%	76%
42b	Were you restrained while in the police custody suite?	16%	18%
43	Were you injured while in police custody, in a way that you feel is not your fault?	15%	24%
44	Were you told how to make a complaint about your treatment?	15%	13%
<b>SECTION 4: Health care</b>			
46	Did you need to take any prescribed medication when you were in police custody?	32%	49%
47	For those who were on medication: were you able to continue taking your medication?	35%	36%
48	Did someone explain your entitlement to see a health care professional if you needed to?	37%	35%
49	Were you seen by the following health care professionals during your time in police custody:		
49a	Doctor	50%	47%
49b	Nurse	16%	21%
	Percentage seen by either a doctor or a nurse	56%	54%
49c	Paramedic	0%	4%
49d	Psychiatrist	0%	3%
50	Were you able to see a health care professional of your own gender?	32%	27%
51	Did you have any drug or alcohol problems?	47%	54%
	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?	76%	42%
53	Were you offered relief medication for your immediate symptoms?	44%	31%
54	For those who had been seen by health care, would you rate the quality as good/very good?	24%	29%
55	Do you have any specific physical health care needs?	44%	32%
56	Do you have any specific mental health care needs?	12%	24%