

Report on an inspection visit to the British Transport Police custody suite

by HM Inspectorate of Constabulary
and Fire & Rescue Services and
Care Quality Commission
23 June–4 July 2025

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Fact page

Note: Data supplied by the force.

Force

British Transport Police

Chief constable

Lucy D'Orsi

Police authority

British Transport Police Authority

Geographical area

England, Scotland and Wales

Date of last police custody inspection

6–16 January 2020

Custody suite

Brewery Road, Islington, London

Annual custody throughput

3,335 in the year ending 31 March 2025.

Of this annual throughput, 3,211 people (out of 3,335) were detained at Brewery Road custody suite. The remaining 124 were detained at Wembley Park custody suite, a smaller site that we didn't inspect.

Introduction

This report describes our findings following an inspection of British Transport Police (BTP)'s custody facility at Brewery Road, Islington, London. The facility has 20 individual cells and is BTP's main custody suite. A second custody suite at Wembley Park is a temporary site used for specific events only. For this inspection we visited the main custody suite at Brewery Road. All performance data we refer to is relevant to this suite only.

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and the Care Quality Commission (CQC) jointly carried out the inspection between 23 June and 4 July 2025. It is part of our programme of inspections covering every police custody suite in England and Wales. These inspections are part of the police effectiveness, efficiency and legitimacy (PEEL) inspection programme and contribute to the UK's response to its international obligations under the [United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment](#).

During our inspection, we held interviews and focus groups with BTP [personnel](#) and other interested parties. We also carried out observations in the custody suite, and we audited custody records, data and documents.

In our inspection, we assessed the effectiveness and efficiency of BTP's custody services against the [characteristics of good](#) listed under core question 9 of: How good is the force at providing a safe and lawful custody environment?

The characteristics of good indicate the performance a force needs to demonstrate to achieve a 'good' grade. The characteristics of good for question 9 require a force to show that it:

- protects the safety and well-being of detainees;
- protects detainees from neglect and harm by recognising and meeting their needs;
- follows the [Police and Criminal Evidence Act 1984 codes of practice](#) and the [College of Policing authorised professional practice](#) and makes sure detainees can exercise their legal rights;
- makes sure it assesses, manages and regularly reviews any risk detainees pose to themselves and/or others throughout detention and on release;
- makes sure any use of force in custody is lawful, necessary and proportionate, and is subject to robust scrutiny; and

- makes sure detainees have access to a range of appropriately staffed and well-managed healthcare services.

Before our inspection, BTP provided us with relevant policies and data. This showed that in the year ending 31 March 2025, 3,211 detainees were booked into custody at the Brewery Road facility. Of these, 2,820 were adults and 385 were [children](#). A further six detention records didn't include a date of birth. The median length of adult detention was 12 hours 39 minutes. For children, the median length of detention was 7 hours 22 minutes.

Overall, we found that BTP's custody provision was adequate. This assessment is based on the force demonstrating some of the characteristics of good. We identified three [areas for improvement](#).



Lee Freeman KPM

His Majesty's Inspector of Constabulary

Custody services

Adequate

British Transport Police (BTP) is adequate at providing a safe and lawful custody environment.

Promising practice

The force has effective processes in place for managing detainee handovers between teams

The force manages handovers between custody teams professionally, and all [officers](#) and [staff](#) (including healthcare professionals) attend. The handovers take place in the custody area, which has CCTV and audio recording.

The outgoing [custody officers](#) brief the incoming team. This briefing covers any risks detainees may present, as well as case progression and the expected next actions. After the handover, members of the incoming team visit all detainees to speak to them and check their welfare.

This is an effective process. It allows custody officers to use the handover information to assess each detainee. Officers and staff told us that the handovers helped them feel better informed about the plan for each detainee.

Areas for improvement

The force should review its governance policies and procedures to make sure it gives its custody officers and staff effective continuous professional development so that their decision-making is consistent, accurate and appropriate

The force doesn't have an agreed custody operating policy. This means it can't give [officers](#) and [staff](#) effective training on making, implementing and reviewing decisions. It also can't be sure all decisions that officers and staff make about detainees are consistent.

During our inspection, we found that the force had dedicated arrangements for custody inspectors. These arrangements give teams valuable support, but they lack resilience and don't include effective succession planning.

For example, we found inconsistent approaches to protecting the dignity and welfare of detainees. We also found inconsistent approaches to giving detainees access to toilet facilities while they waited to be booked into custody. In some instances, officers and staff denied detainees access during long waiting times for booking in.

We also found a lack of consistency in the way the force calculated and recorded detention times. Force data showed that the median time from arrival to detention being authorised was 24 minutes for adults and 27 minutes for [children](#). But we found that custody sergeants recorded arrival times in different ways. Some recorded the arrival time as when the van arrived on the public road outside the custody suite, while others recorded it as when the van was in the secure area outside the custody suite. Officers and staff we spoke to during our inspection told us that it could sometimes take more than an hour for the van to move from the road outside into the secure area.

Officers and staff also told us that the time from arrival to detention being authorised was often longer than the time shown by the force data. They said that this was especially the case when temporary staff covered custody roles.

The force doesn't have a standardised training and continuous professional development (CPD) plan for [personnel](#) who temporarily carry out detention officer and custody sergeant roles. Although all custody sergeants take part in the appropriate national training programmes, there are gaps in CPD and skill-refreshing opportunities for those who provide temporary cover on an ad-hoc basis. For these temporary custody sergeants, there is often a long gap between receiving official training and covering custody duties, which results in skill depletion and reduced awareness of process. This leads to longer waiting times for detainees.

More broadly, we also found that permanent [custody officers](#) and staff received no CPD in 2024, and that the force didn't have any planned CPD for them until October 2025. This means that custody personnel hadn't been given training on any changes to legislation or [authorised professional practice](#) – for example, on the changes relating to strip searches.

We found that a small number of custody officers had used their initiative by planning training for themselves and their detention officers. But this training was inconsistent across teams, and the force didn't have any records of it.

During our inspection, we also found a lack of consistency in the way the force detained children. Senior leaders expressed the force's commitment to keeping children out of custody by only making arrests for high-harm offences. But frontline officers appeared to have little knowledge of this expectation. Officers told us this wasn't part of their decision-making process when arresting children. Custody sergeants also told us they used the same rationale to authorise the detention of children as the one they used for adults.

The force should make sure it follows authorised professional practice by completing individual risk assessments before using force to remove detainees' clothing, footwear and other items, such as jewellery

The [College of Policing's authorised professional practice \(APP\) on custody](#) states that the use of force (including the decision to remove clothing) should be subject to an individual [risk assessment](#). This must include consideration of other options, such as increased observation levels.

We found that the force didn't consistently follow APP in this area, and that it routinely removed the clothing of violent detainees without completing a risk assessment. We also saw two instances in which [officers](#) used force to remove clothing and jewellery from two [child](#) detainees. Both children were subject to level 4 constant observations, so the risk of them self-harming or posing a risk to others was low.

We also found examples of custody [personnel](#) unnecessarily removing clothing with cords. [Custody officers](#) told us they removed all clothing with cords, as well as laces from footwear, regardless of the risk presented by the detainee, and regardless of whether or not the detainee was violent.

This isn't in line with APP, which states that the removal of cords should be based on a risk assessment.

The force should improve the way it records information, so it can effectively assess and manage detainees' risk before they leave custody

During our inspection, we found that pre-release [risk assessments](#) didn't contain enough detail of the risks presented by detainees, or any information about how to mitigate that risk when they left custody. We also found that [officers](#) and [staff](#) didn't always complete these risk assessments in line with the [College of Policing's authorised professional practice \(APP\) on custody](#), which states that the detainee should be present when the risk assessment is completed.

When detainees are transferred to court, detention officers complete digital person escort records to a high standard. But [custody officers](#) and staff don't sufficiently oversee the transfer process, which means they can't always carry out a thorough pre-release risk assessment.

Main findings

The force doesn't have fully effective governance and quality assurance processes, which means it can't adequately manage detainees' safety and well-being

BTP has monthly tactical and quarterly strategic governance arrangements, including meetings, to make sure its custody service is safe and lawful.

The force understands some of its responsibilities under the [public sector equality duty](#), and it monitors custody data to identify [disproportionality](#). But it could improve in this area. For example, custody personnel told us they had received limited training on how to manage detainees with mental health or neurodivergent conditions and child detainees.

The force needs to improve the way it collects data, so it can hold strategic local-authority and healthcare partners to account. This would improve support for children and [vulnerable adults](#) in custody. At the time of our inspection, the force didn't collect data in relation to:

- mental health referral waiting times; or
- access to [secure accommodation](#) for detainees when there are mental health concerns.

The force is open to external scrutiny, but force leaders couldn't give us examples of the impact this had on improving custody services. The independent custody visitors scheme is run by the Mayor's Office for Policing and Crime. Independent custody visitors visit the suite twice a month, and they reported a good relationship with custody personnel.

The force has arranged for members of the BTP [independent advisory group](#) to form a specific custody panel. This panel first met in June 2025, and it will meet quarterly, with the next meeting due to take place in October 2025.

The force has some processes in place to protect detainees from neglect and harm, but it needs to make improvements

The custody suite is a safe environment that promotes the security, privacy and dignity of detainees.

We inspected 5 of the 20 cells, and we found that 1 cell had a potential [ligature point](#). At the time of our inspection, custody personnel didn't know about this potential ligature point. They have since made sure that enhanced observation levels are in place for any detainees using that cell, while they wait for a permanent fix.

Generally, custody personnel take steps to consider detainees' dignity, but the force could improve the process for handing out toilet paper. At the time of our inspection, detainees had to activate the cell call bell if they needed toilet paper, and we saw that there was often a delay in call bells being answered.

The force makes sure detainees can understand their rights and entitlements. For example, it has appropriate telephone interpretation services in place.

We saw custody officers and staff trying to respect detainees' privacy when having conversations with them. For example, custody sergeants used a low tone of voice and made sure they leaned forward as much as possible when speaking to detainees.

However, the three booking-in desks are close to each other, and the sound screens are minimal. This often affects detainees' privacy as they can be overheard when describing their physical and mental health conditions.

Positively, we found that custody sergeants always allocated a female officer to oversee female children's welfare during their time in custody.

The force makes sure detainees know their legal rights

At each booking-in desk, posters show clear information about making complaints. This information includes advice on speaking to the duty inspector or the [Independent Office for Police Conduct](#). Custody personnel told us they generally referred complaints made to them to the duty inspector.

The force aims to carry out reviews in person to authorise continued detention, and we saw this happen regularly. In our audits and observations, we found that most reviews were carried out to an acceptable standard. But several reviewing inspectors had used a template that made it difficult to pick out the relevant parts. For example, they often relied on a template with yes or no answers, and reviewing officers didn't always delete the text that didn't apply. This made some entries difficult to follow.

We found examples of reviewing officers considering the needs of children, people with mental health difficulties and other vulnerable adults. But some custody record entries were brief and generic, which made it difficult to establish if the needs of each detainee had been considered.

Arresting officers don't always give custody sergeants enough information about why an arrest was necessary and why it couldn't be dealt with via other means, such as arrest by appointment or [voluntary attendance](#). Custody officers often have to prompt arresting officers for this information.

Custody officers carry out the booking-in process thoroughly and professionally. They give detainees information about how to exercise their legal rights. When detainees decline their right to legal advice, custody officers ask questions and explain this ongoing right, telling them they can change their mind at any time.

The force makes sure any use of force in custody is lawful, necessary and proportionate, and subject to robust scrutiny

We reviewed 23 use of force incidents by examining custody records and CCTV footage, where available.

Generally, we found that use of force was proportionate to the risk or threat posed. We saw four cases in which officers didn't use unarmed tactics correctly and in line with training. But in general, custody sergeants show good leadership and oversight of incidents, managing the safety of detainees and officers well. We noted some consistently good examples, in which custody personnel tried to de-escalate situations involving violent detainees.

When officers had applied handcuffs, leg restraints or spit guards, they had mostly applied them correctly, and they were regularly checked.

During our inspection, we saw two cases involving strip searches, in which it was suspected that the detainee had a concealed item. In both cases, custody personnel carried out and recorded the searches well. They also made sure the detainees weren't left unclothed. This helps to protect and preserve detainees' dignity.

In 13 out of 18 incidents we reviewed, custody officers recorded authorising the removal and replacement of a detainee's clothing for safety reasons. We gave feedback to the force about the incidents in which authorisation was missing.

The force has supervisory scrutiny of use of force incidents and strip searching in custody. Despite this process, the force has failed to identify some concerning practices. For example, in some cases, we found a discrepancy between the type of search supervisors authorised and the search that took place. In our audits and observations, we found accuracy problems with the recording of strip searches. One record we reviewed was a search carried out on the grounds of safety/welfare concerns for the detainee. But when we reviewed the CCTV, the searching officer carrying out the strip search was looking for a concealed item.

We pointed this out to the force during our inspection, and it immediately changed its review process so it can identify any similar concerns straight away. This is positive.

The force makes sure effective healthcare is in place and well managed, but access to police systems would support more accurate detainee updates

The dedicated custody inspector and NHS England carry out contract monitoring for the force.

Healthcare professionals (HCPs) and [liaison and diversion \(L&D\)](#) staff are based in the custody suite. This means detainees' healthcare needs are assessed promptly and efficiently. There is also signposting for detainees about diversionary opportunities and further support to help reduce reoffending, such as drug and alcohol services.

But HCP and L&D staff told us they didn't have access to police systems, which delayed the recording of their updates on detainees' custody records. HCPs and L&D staff have to send the custody sergeant an email that contains the summary of their consultation with the detainee. This causes a delay and creates extra work for the custody sergeant.

There is good supervision and well-being support in place for all HCPs. The staffing levels are sufficient to make sure HCPs are available in the suite 24 hours a day. L&D staff are available from 8am to 9pm every day except Sunday.

HCPs assess detainees in an appropriate clinical space. At the time of our inspection, privacy screens were available. But clinical room doors are sometimes left open during consultations, which could compromise confidentiality.

Under the supervision of an HCP, detainees can access products to help them with nicotine cravings, as well as antibiotics, symptomatic relief for drug and alcohol withdrawal, and their prescribed opioid substitution medication.

HCPs gain detainees' consent to share information appropriately, and they make referrals to support services, including substance-misuse support, in the detainee's local area. Detainees are assessed in London but may live anywhere in the UK, so this is positive.

At the time of our inspection, custody officers and staff told us they were concerned that the relationship with the current healthcare team, and the positive ways of working, may be affected by an imminent change of provider. This would mean new HCPs being introduced. The force knows about these concerns and is making plans to work with the new provider to make sure there continues to be an effective service during the transition period.

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