

Report on an inspection visit to police custody suites in the Metropolitan Police Service

by HM Inspectorate of Constabulary
and Fire & Rescue Services and
Care Quality Commission
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Contents

Fact page	1
Summary	4
Introduction	12
Section 1. Leadership, accountability and working with partners	14
Section 2. Pre-custody – first point of contact	20
Section 3. In the custody suite – booking-in, individual needs and legal rights	22
Section 4. In the custody cell – safeguarding and healthcare	31
Section 5. Release and transfer from custody	47
Section 6. Summary of cause of concern, recommendation and areas for improvement	49
Section 7. Appendices	54
Appendix I – Methodology	54
Appendix II – Inspection team	57

Fact page

Note: Data supplied by the force.

Force

Metropolitan Police Service

Chief constable

Sir Mark Rowley

Police and crime commissioner

The Mayor's Office for Policing and Crime (MOPAC)

Geographical area

London

Dates of last police custody inspection (in three tranches)

- July 2018
- June 2016
- November 2015

Custody suites

- Holborn
- Islington
- Charing Cross
- Stoke Newington
- Wood Green
- Bethnal Green
- Fresh Wharf
- Romford
- Leyton
- Colindale

- Wembley
- Heathrow
- Croydon
- Brixton
- Wandsworth
- Lewisham
- Bexleyheath
- Bromley
- Walworth
- Acton
- Hammersmith
- Kingston

There are also eight contingency suites:

- Kentish Town
- Charing Cross Ground Floor
- Ilford
- Harrow
- Sutton
- Plumstead
- Peckham
- Hounslow

Annual custody throughput

125,730 (2024)

Custody staffing

- One chief superintendent
- Two superintendents (covering three positions)
- Five chief inspectors (covering seven positions)
- 103 inspectors
- 406 sergeants
- 16 constables
- 682 designated detention officers
- Nine Band E [staff](#)
- Six Band D staff

Health service provider

Internally provided by Metropolitan Police Service:

- One healthcare director (Band H)
- Six clinical managers (Band V)
- 118 healthcare practitioners (Band P1)
- One forensic healthcare services manager (Band D)
- Two forensic healthcare services administrators (Band E)
- One constable

Summary

This report describes our findings following an inspection of the Metropolitan Police Service custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and the Care Quality Commission (CQC) in February and March 2025. It is part of our programme of inspections covering every police custody suite in England and Wales.

The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to detaining people safely and respectfully, with a particular focus on [children](#) and [vulnerable](#) adults.

To help the force improve, we have made one recommendation to it and its [police and crime commissioner](#). This addresses our main [cause of concern](#).

We have also highlighted a further 20 [areas for improvement](#). These are set out in [section 6](#) of this report.

Leadership, accountability and working with partners

The Metropolitan Police Service has a clear management structure for providing custody services. A commander has overall responsibility for criminal justice, and a chief superintendent provides the strategic leadership for custody. There are 2 superintendents and 5 chief inspectors who manage the day-to-day running of the force's 22 operational custody suites and 8 contingency suites.

Until recently, the force's senior leadership team had limited oversight of custody. But in 2024, the custody senior leadership team developed clearer governance arrangements, including setting up assurance boards. It set up the necessary operational and strategic meetings to oversee the safe and respectful provision of custody services.

Since our last inspections, the force has made some progress in improving custody services. But some areas still need to improve. These include:

- the way the force governs and oversees the use of force;
- risk management;
- reviews under the [Police and Criminal Evidence Act 1984 \(PACE\) code C 2023](#); and

- the collection and scrutiny of accurate and relevant data.

This is a cause of concern.

There are enough trained [personnel](#) to provide custody services. But during busy periods, custody personnel are sometimes stretched. This means they can't always meet detainees' needs, such as by giving them access to showers and exercise yards.

We commend the way in which the force maintains its custody suites to provide a safe environment. We found that only Wandsworth and Peckham custody suites had potential [ligature points](#) in the cells. We tested 22 suites, so this is a good outcome. We usually find much greater numbers of potential ligature points in suites in other police forces in England and Wales.

However, not all suites are well maintained, and not all have enough facilities to meet detainees' needs, particularly those with mobility difficulties.

Initial training for [custody officers](#) and detention officers follows the [College of Policing](#)'s nationally accredited course.

The force has adopted the College of Policing's [authorised professional practice \(APP\)](#) on detention and custody, and it has a clear operating policy for custody. But not all personnel follow this guidance, particularly for managing risk in custody and when releasing detainees.

We found that the oversight and governance of custody performance had decreased since our last inspections. However, in 2024, the custody senior leadership team started to monitor areas of custody performance, such as overall throughput, waiting times, children, strip search, detention times and refused detentions. In January 2025, it introduced more areas of scrutiny, including pre-release [risk assessments](#), safe systems of work, PACE reviews and use of force.

But not all data the force collects is accurate, and it doesn't collect all relevant data. This reduces how well it can manage performance and make improvements in some areas.

The force monitors data on throughput and strip search by gender, age and ethnicity. However, its data shows that the way it records self-defined ethnicity isn't good enough. This limits how well the force can understand whether outcomes are fair and equal for all detainees.

We found that reviews of detention didn't always follow the requirements of PACE code C. Reviews were generally poorly recorded, frequently carried out by telephone due to the travelling distance between suites, and too many were listed as sleeping reviews (carried out when detainees were asleep). In our view, the force could have carried out some of these reviews when the detainees were awake.

The governance and oversight of use of force incidents is poor. Our review of use of force incidents suggests that when force is used in custody, it is generally justified, proportionate and necessary. But the force's quality assurance processes aren't robust enough for it to understand and evidence this itself.

In January 2025, the custody leadership team started to review 30 use of force incidents per month. The team reviews the quality of records, but it doesn't review the CCTV footage of each incident. The scrutiny of use of force incidents should be more robust. The force should also [dip sample](#) a greater number of incidents, given the high number of detainees in the Metropolitan Police Service's custody per year.

More positively, we reviewed 64 cases on CCTV and found no significant learning for the Metropolitan Police Service in any of them. This is a much better outcome than what we normally find in other custody suites in England and Wales.

The quality of recording on custody records overall isn't good enough. We saw some very detailed entries on detention logs, but the recording didn't always reflect some of the good practices we observed.

When custody officers produce detainee care plans, they don't always set appropriate observation levels to manage risk. When releasing detainees, they don't always complete the pre-release risk assessment processes well enough. And some detention officers don't record cell visits or aspects of detainee care well enough.

The force understands its responsibilities under the [public sector equality duty](#), but it doesn't meet them in all areas, such as self-defined ethnicity recording. It monitors [disproportionality](#) in both strip search data and overall detainee throughput data. Custody personnel have received some training on the [Equality Act 2010](#), and on topics such as general vulnerability and dealing with detainees with mental health conditions.

The force clearly prioritises diverting children away from custody. It works with the [youth justice services](#) to achieve this.

Pre-custody – first point of contact

Frontline [officers](#) have a reasonable understanding of what makes a person vulnerable. They take account of this when deciding what action to take at incidents, such as making an arrest or using other options.

Officers told us they only arrested children as a last resort, which follows the force's strategic aims for [safeguarding](#).

There is limited support for frontline officers when they deal with people with mental health conditions. Mental health professionals are based in control rooms and police vehicles, but there isn't a consistent service. This means they can't always give advice to officers who are dealing with incidents. Officers have access to a phone line for speaking to a mental health professional 24 hours a day, 7 days a week, but they sometimes face long waits to get through.

In the custody suite – booking-in, individual needs and legal rights

During our inspection, we found that custody personnel were always respectful towards detainees, and they showed compassion during their interactions with them.

The booking-in areas in most suites offer limited privacy, despite some having privacy barriers to separate the booking-in desks. This is due to the close proximity of booking-in positions and the acoustics in these areas.

In some suites, the shower doors are too low. This means they aren't suitable for female detainees.

Custody officers usually ask female detainees if they would like to speak privately to a female member of custody personnel, as is good practice. But we didn't always see this reflected in the records. It also wasn't clear whether female detainees were also assigned a female member of custody personnel to oversee their care.

Custody personnel generally understand the needs of detainees from [protected](#) or minority groups, and they do their best to meet these needs. But the lack of facilities in suites can hinder their efforts.

Not all areas in custody are adapted well enough for detainees with mobility impairments. However, there are adaptations for detainees with visual impairments, and there is provision for those with hearing difficulties.

The force uses LanguageLine electronic tablets, which provide interpreting services for those who don't understand English.

Detainees can usually observe their faith, but there is an inconsistent range of religious texts in the suites. Religious materials aren't always stored in a neat and respectful way.

The force is generally good at identifying risk, but it is less good at managing ongoing risk. The force doesn't always follow APP guidance for risk management. This forms part of our cause of concern.

Waiting times for booking-in are generally short. But during busy periods, some detainees wait for long periods to be booked in, sometimes in police vehicles. Although custody officers carry out risk assessments before detainees enter custody, this rarely results in children and vulnerable adults being prioritised for booking-in.

The force has its own observation levels, which aren't consistent with APP. Observation levels for detainees who show signs of intoxication aren't always set as level 2 with rousing checks, and the force doesn't use level 3 CCTV observations.

In all the cases we observed and reviewed, custody officers appropriately authorised detention. They complete a thorough booking-in process, during which they consider detainees' needs. Custody officers clearly explain legal rights and entitlements to detainees. In most cases, they make sure detainees can exercise them promptly.

Reviews of detention don't always comply with the requirements of PACE code C. Custody inspectors don't always carry out reviews well enough or in the detainees' best interests.

In the custody cell – safeguarding and healthcare

The approach to detainee care is good and custody personnel show a caring attitude towards detainees. During booking-in, custody officers tell detainees what provisions are available to them, such as exercise, showers, reading materials, and food and drink.

When force is used in custody, it is usually proportionate to the risk or threat. But the recording of incidents is sometimes poor and quality assurance is limited. As a result, it is difficult for the Metropolitan Police Service to show that when it uses force in custody, it is necessary, justified and proportionate.

There is a strong focus on safeguarding detainees, especially children. Rigorous arrangements are in place to monitor and safeguard children throughout their detention and beyond. The force expects custody officers to have a regular dialogue with investigating officers about any safeguarding concerns. At an early stage in every detention of a child, custody personnel contact the relevant local authority to ask for and exchange information about the child. This means they can start arranging appropriate post-release support at the earliest stage.

The force assigns both girls and boys a named officer to care for them during their time in custody. This goes beyond the legal requirement (section 31 of the [Children and Young Persons Act 1933](#)), which states that girls under the age of 18 must be under the care of a woman while detained, while being conveyed to and from court, and while waiting to be conveyed to and from court.

Less positively, even though the force's own custody policy requires it, not every child sees a non-policing professional, such as a [liaison and diversion \(L&D\)](#) practitioner or healthcare practitioner (HCP).

During our observations in the suites, we saw that custody personnel consistently contacted [appropriate adults \(AAs\)](#) early, within 45 minutes for both children and vulnerable adults. This is good. As part of its recently introduced performance-monitoring measures, the force now regularly monitors how promptly it makes AA requests. This is a positive development.

While the force has begun to gather information on how quickly it contacts AAs, it doesn't yet monitor how long it takes for AAs to arrive.

At the time of our inspection, the force was trialling new child-first arrangements at two suites (Brixton and Wood Green), where extra measures were in place to give children a better experience in police custody. This was part of the Child First Custody Training and Research Pilot (ChiRP). As well as adopting a 12-hour (rather than 24-hour) custody timescale, children taken to these suites could access specially trained legal advisors, and bespoke cells, booking-in desks and interview rooms with more child-friendly decoration and furnishings. Custody personnel also scrutinised the progress of children's cases even more closely. This initiative is positive as it could result in children in these suites having a better experience. However, at the time of our inspection, the force hadn't assessed any data or other information to inform its understanding of any impact the initiative could make. After our inspection, the force told us it had finished the pilot and was now reviewing its impact.

The situation for children who are charged and remanded into custody remains poor, with few children transferred to local authority accommodation.

The Metropolitan Police Service directly employs HCPs to provide healthcare services to detainees. It allocates HCPs to each custody suite, and they provide healthcare cover 24 hours a day, 7 days a week. They offer a range of services to detainees, such as reviewing injuries, support in managing long-term conditions, administering medicines and managing withdrawal symptoms, as well as carrying out forensic sampling. They also carry out mental state assessments and give case management recommendations out of hours and when there are no L&D practitioners in the suite.

Due to the functionality of the force's IT system, Connect, the force can't gather all relevant healthcare data. And data extraction from Connect in relation to [Mental Health Act 1983 \(MHA\)](#) assessments and the use of section 136 of the MHA in custody remains poor. The force can't identify how often it uses section 136, or how long detainees spend in custody while waiting for an MHA assessment and/or transfer to a mental health bed or a health-based place of safety. This means outcomes for detainees subject to these processes aren't clear.

In the force's geographical area, there 32 local authorities, and each has different arrangements for providing out-of-hours mental health services. We received mixed feedback about the timeliness of MHA assessments. Custody personnel told us there were often long waits for suitable beds for detainees who needed hospital admission after MHA assessments.

In most cases, HCPs promptly review detainees with substance misuse problems. Opiate substitution medication can continue to be prescribed for detainees who are prescribed it in the community.

HCPs can give detainees medicines after assessment and in line with the force's patient group directions.

Release and transfer from custody

The force doesn't always release detainees safely. Not all pre-release risk assessments contain enough detail to show how the force has identified and addressed risks such as self-harm. The quality of pre-release risk assessments and the fact that the force doesn't always carry them out with the detainee present form part of our cause of concern.

Detention officers complete the digital person record and arrange transport for detainees who are attending court or being recalled to prison. They complete these records well, and they include the relevant risk, health and medical information. Custody officers oversee this process, but they don't routinely speak to detainees leaving custody in these circumstances to carry out a pre-release risk assessment. This practice doesn't follow APP guidance.

The force's transport contractor can't always promptly collect remanded detainees to take them to court. Sometimes, the courts don't have capacity to see all remanded detainees, and on some days, particularly Mondays, there are substantial gaps in court capacity. This means some detainees spend up to 48 hours longer in police custody than they should. This is a poor outcome for detainees, and it places extra pressure on police custody suites.

Cause of concern and recommendation

Cause of concern

The force doesn't oversee a wide enough range of custody services to make sure it can protect the safety and well-being of detainees, and improve the outcomes for those with mental health conditions.

Recommendation

With immediate effect, the force should strengthen its governance of custody and its quality assurance process. It should:

- further develop the way it scrutinises use of force incidents to include comprehensively auditing records and reviewing CCTV footage;
- make sure all custody personnel follow [authorised professional practice \(APP\)](#) guidance on managing risk, particularly for detainees under the influence of alcohol or drugs, and that pre-release [risk assessments](#) are thorough and completed with the detainee present;
- make sure all [personnel](#) follow the [Police and Criminal Evidence Act 1984 \(PACE\)](#) and its codes of practice, particularly when carrying out reviews of detention under section 40 of the Act;
- develop processes for comprehensively auditing custody records to include qualitative aspects of performance; and
- gather and monitor data to make sure it understands the way it uses section 136 of the [Mental Health Act 1983](#) in custody, as well as waiting times for mental health assessments.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HMICFRS and CQC. These inspections are part of the joint work programme of the criminal justice inspectorates 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 \(OPCAT\)](#).

The national rolling programme of police custody inspections, which began in 2008, makes sure that custody facilities in all 43 forces in England and Wales are inspected regularly.

OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of, and conditions for, detainees. HMICFRS and CQC are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force fulfils its responsibilities when detaining people in police custody, and the outcomes for them. This includes how safely they are managed and how respectfully they are treated.

Our assessments are made against the criteria set out in our '[Expectations for police custody](#)'. These standards are underpinned by international human rights standards and are developed by the two inspectorates. We consult other expert bodies on them across the sector and they are regularly reviewed. This helps to achieve best custodial practice and promote improvements.

The expectations are grouped under five inspection areas:

- leadership, accountability and working with partners;
- pre-custody – first point of contact;
- in the custody suite – booking-in, individual needs and legal rights;
- in the custody cell – [safeguarding](#) and healthcare; and
- release and transfer from custody.

The inspections also assess compliance with PACE 1984, its codes of practice and the College of Policing's [authorised professional practice – detention and custody](#).

The methodology for carrying out the inspections is based on:

- a review of a force's strategies, policies and procedures;
- an analysis of force data;
- interviews and focus groups with personnel;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also analyse a representative sample of custody records from all suites in the force area for the week before the inspection starts. For the Metropolitan Police Service, we analysed a sample of 175 records. The methodology for our inspection is set out in full at [Appendix I](#).

Terminology in this report

Our report contains references to 'national' bodies, strategies, policies, systems, responsibilities, processes and data. In some instances, 'national' means applying to England and Wales. In others, it means applying to England and Wales and Scotland, or the whole of the United Kingdom.

Section 1. Leadership, accountability and working with partners

Expected outcomes

[Chief officers](#) have a clear priority to protect the safety and well-being of detainees and to divert vulnerable people away from custody.

Leadership

The Metropolitan Police Service has a clear management structure for providing custody services. A commander has overall responsibility for criminal justice, and a chief superintendent provides the strategic leadership for custody. There are 2 superintendents and 5 chief inspectors who manage the day-to-day running of the force's 22 operational custody suites, and the 8 contingency custody suites that the force uses when it needs to.

Until recently, the senior leadership team had limited oversight of custody. But in 2024, the custody senior leadership team developed clearer governance arrangements, including setting up assurance boards. It set up the necessary operational and strategic meetings to oversee the safe and respectful provision of custody services. These custody-specific meetings include:

- monthly custody senior leadership team meetings;
- an assurance board;
- an [organisational learning](#) board;
- a training board;
- a healthcare board;
- a finance board; and
- a governance board, which oversees all custody-related boards and meetings.

These assurance boards report to force-level performance and assurance boards at commander level when necessary.

The last time we inspected the Metropolitan Police Service custody facilities, we carried out three separate inspections, each covering part of the custody estate. These inspections took place in 2015, 2017 and 2018. Since those inspections, the force has made some progress in improving custody services. But some areas still need to improve, and the force hasn't sufficiently addressed all the recommendations that followed our last inspections. These include:

- the way the force governs and oversees the use of force;
- risk management;
- reviews under PACE code C; and
- the collection and scrutiny of accurate and relevant data.

This is a cause of concern.

Despite having enough trained personnel who provide custody services as their full-time role, the force accepts that its resourcing planning model is lean. It relies on personnel working overtime to fill gaps.

The establishment of personnel for custody consists of:

- 5 chief inspectors;
- 103 inspectors;
- 406 custody sergeants; and
- 682 designated detention officers.

The custody senior leadership team monitors staffing levels at daily tasking meetings. It can move personnel between custody suites when it needs to. This allows it to balance demand and resources on daily shifts. But during busy periods, custody personnel are sometimes stretched. This means they can't always meet detainees' needs, such as by giving them access to showers and exercise yards.

At the time of our inspection, the force was trialling a cell allocation unit. This team works 24 hours a day, 7 days a week to manage cell allocation based on demand and the capacity of custody suites. The aim of the trial is to make the custody process more efficient for both detainees and personnel. If successful, the force will implement this system across all its custody suites.

We commend the way in which the force maintains its custody suites to provide a safe environment. We found that only Wandsworth and Peckham custody suites had potential ligature points in the cells. We tested 22 suites, so this is a good outcome. We usually find much greater numbers of potential ligature points in suites in other police forces in England and Wales.

Custody personnel carry out their daily and weekly suite checks well. These include identifying and dealing with potential ligature points. In our view, these thorough checks are the reason why we found so few potential ligature points.

However, not all suites are well maintained, and not all have enough facilities to meet detainees' needs. For example, too many suites don't have sinks in cells, or don't have adequate holding rooms or exercise yards.

At the time of our inspection, we gave the force an illustrative physical conditions report, and it immediately began to act on our findings. We said that the potential ligature points at the Wandsworth suite were due to the toilet design. The force closed this suite immediately to install new toilets. This shows how seriously it takes the safety of detainees in its care.

Initial training for custody officers and detention officers follows the College of Policing's nationally accredited course. And before custody personnel take up their duties, they also shadow more experienced colleagues.

The force provides four days of refresher training every year. Personnel also receive weekly email updates from the chief superintendent. But personnel we spoke to had mixed views about the quality of their training and what they learned from it.

The force has adopted the College of Policing's APP on detention and custody, and it has a clear operating policy for custody. But not all personnel follow this guidance, particularly for managing risk in custody and when releasing detainees.

When adverse incidents take place, the force manages them appropriately. It properly records and investigates them, and the senior leadership team oversees the process. Through the chief superintendent's weekly emails, all custody personnel receive information about learning from these incidents.

Accountability

Since our last inspections, the oversight of custody performance has decreased. However, in 2024, the custody senior leadership team started to monitor areas of custody performance, such as overall throughput, waiting times, children, strip search, detention times and refused detentions. In January 2025, it introduced more areas of scrutiny, including pre-release risk assessments, safe systems of work, PACE reviews and use of force.

But not all data the force collects is accurate, and it doesn't collect all relevant data. This reduces how well it can manage performance and make improvements in some areas.

For example, the force doesn't routinely gather information about:

- the times that it requests AAs, and when they arrive at custody;
- the use of section 136 of the MHA in custody;
- how long detainees wait for an assessment under section 2 of the MHA; and
- the quality of custody records, including care plans, observation levels, pre-release risk assessments and detainee care.

We found that the force was inaccurately recording data on the use of force and detainee ethnicity. However, the force was working to improve this before and during our inspection. At the time of our inspection, compliance with self-defined ethnicity recording was at 75 percent, but the force needs to do more to further improve this rate. Not having this data limits how well it can understand whether outcomes are fair and equal for all detainees.

At the time of our inspection, the force didn't record all use of force incidents on custody records or on use of force forms. It monitors data on throughput and strip search by gender, age and ethnicity. The force monitors and scrutinises its use of strip search to a high standard. The force should apply this level of scrutiny to other important areas of custody performance.

There are enough custody inspectors, but the force doesn't expect them all to carry out reviews of detention. This means that the workload for those who do carry out reviews is high, with each inspector covering two suites.

We found that reviews of detention didn't always follow the requirements of PACE code C. Reviews were generally poorly recorded, frequently carried out by telephone due to travelling distance between suites, and too many were listed as sleeping reviews. In our view, the force could have carried out some of these reviews when the detainees were awake.

The governance and oversight of use of force incidents is poor. Our review of use of force incidents suggests that when force is used in custody, it is generally justified, proportionate and necessary. But the force's quality assurance processes aren't robust enough for it to understand and evidence this itself.

In January 2025, the custody leadership team started to review 30 use of force incidents per month. The team reviews the quality of records, but it doesn't review the CCTV footage of each incident. The scrutiny of use of force incidents should be more robust. The force should also dip sample a greater number of incidents, given the high number of detainees in the Metropolitan Police Service's custody per year.

The force doesn't monitor its use of restraints in custody at all. This means it doesn't fully understand the circumstances in which it uses restraints on detainees in custody suites, sometimes for considerable periods of time.

We found that some of the force's data on use of force and restraint in custody was unreliable. For example, in our review of the CCTV footage of incidents, we found that personnel hadn't accurately recorded all the incidents we identified. And not all personnel involved in incidents had completed the required use of force forms.

More positively, we reviewed 64 cases on CCTV and found no significant learning for the Metropolitan Police Service in any of them. This is a much better outcome than what we normally find in other custody suites in England and Wales.

The quality of recording on custody records overall isn't good enough. We saw some very detailed entries on detention logs, but the recording didn't always reflect some of the good practices we observed. Custody personnel rely on dropdown menus and templates, without removing the text that doesn't apply. This leads to confusing and contradictory entries. We found that this was particularly the case with reviews of detention.

When custody officers complete detainee care plans, they don't always set appropriate observation levels to manage risk. When releasing detainees, they don't always complete the pre-release risk assessment processes well enough. And some detention officers don't record cell visits or aspects of detainee care well enough. At the time of our inspection, the force told us it was soon to introduce a pilot, through which detention officers will have access to a mobile app designed to make it easier and faster for them to record cell visits.

The force has limited quality assurance processes for auditing custody records. As a result, it hadn't identified the issues that we found. Too often, the force focuses on identifying that something has been done, rather than whether it was done well.

The force carries out some auditing and dip-sampling in relation to some custody suites, but this isn't formalised. This means that different inspectors complete a different number of audits, or none at all, and they don't document the outcome of any quality assurance. This lack of consistency prevents the force from identifying areas it needs to improve.

The force understands its responsibilities under the public sector equality duty, but it doesn't meet them in all areas, such as self-defined ethnicity recording. It monitors disproportionality in both strip search data and overall detainee throughput data. Custody personnel have received some training on the Equality Act 2010, and on topics such as vulnerability and dealing with detainees with mental health conditions.

The force is open to external scrutiny. Members of the independent custody visitors scheme regularly visit each of the 22 suites, including on weekends and evenings. We spoke to some members of the scheme, who told us they had a good relationship with the force. They also said that when they identified issues, they could raise them either with custody personnel, who dealt with them immediately, or at regular meetings with the custody senior leadership team.

At the time of our inspection, the scheme had 170 volunteer members, and there were plans to increase this to 250 members. The scheme managers know they need a diverse team of volunteers, and the demographics of the scheme are already better than what we usually find in other schemes in England and Wales.

The scheme and its members have the ability and confidence to challenge the force when they need to. It can also help bring about change that benefits detainees and personnel.

MOPAC shows an active interest in custody outcomes, particularly for children. Together with the force, it jointly scrutinises data on children and strip searches.

Working with partners

The force clearly prioritises diverting children away from custody. It works with the Youth Justice Services to achieve this. For example, the [ENGAGE](#) and [DIVERT](#) programmes help children and young adults address the causes of their offending.

The force monitors the number of children who come into custody. During our inspection, we saw that custody officers robustly refused to detain children when appropriate.

However, when children are charged and remanded, too many are detained in custody overnight, even though they should be moved to secure or other [alternative accommodation](#). Outcomes for these children need to improve.

Since our last inspection, few children who needed [secure accommodation](#) were relocated after being charged and before appearing in court. This is a poor outcome for children. The force needs to work strategically to influence partner organisations and negotiate improved accommodation in the London metropolitan area.

The force doesn't adequately monitor or scrutinise data on detainees who need mental health support in custody. This needs to improve. Custody personnel told us there were often long waits for mental health assessments, and for moving detainees to a health-based place of safety. Due to these long waits, the force sometimes uses section 136 of the MHA to move detainees from custody more quickly.

The chief superintendent aims to improve detainee outcomes by working more widely with partner organisations, and has set up a stakeholder event to improve networking. These stakeholders include MOPAC, children's services, the [Youth Board](#), local authorities and academics.

Section 2. Pre-custody – first point of contact

Expected outcomes

Police officers and staff actively consider alternatives to custody. They effectively identify vulnerabilities that may increase individuals' risk of harm. They divert children and vulnerable adults away from custody when detention may not be appropriate.

Assessment and diversion at first point of contact

Frontline officers have a reasonable understanding of what makes a person vulnerable. They take account of factors such as age, gender and appearance when deciding what action to take at incidents, such as making an arrest or using other options.

Officers told us that information from call handlers (who take calls from the public) in the [force's control rooms](#) sometimes wasn't as good as it should be. For example, officers don't always receive all the information, and sometimes they don't receive it quickly enough. They told us this sometimes meant they couldn't explore whether alternatives to arrest were appropriate. They believed this was due to the demand and the resourcing levels in the control rooms.

Officers told us they only arrested children as a last resort, which follows the force's strategic aims for safeguarding. They explore alternatives such as taking them to family members or arranging voluntary interviews.

There is limited support for frontline officers when they deal with people with mental health conditions. Officers told us there were local arrangements in some parts of London. Mental health professionals are based in control rooms and police vehicles, but there isn't a consistent service. This means they can't always give advice to officers who are dealing with incidents. Officers have access to a phone line for speaking to a mental health professional 24 hours a day, 7 days a week, but they sometimes face long waits to get through.

Area for improvement

The force should improve support for frontline [officers](#) by making sure:

- frontline officers have access to timely and good-quality information to help them respond to incidents and make appropriate decisions; and
- advice and assistance from mental health professionals is consistently available to officers across the force, to help them when dealing with people with mental health conditions.

Section 3. In the custody suite – booking-in, individual needs and legal rights

Expected outcomes

Detainees are treated respectfully in the custody suite and their individual needs are identified and met. Detainees' risks are identified at the earliest opportunity and managed effectively. Detention is appropriately authorised. Detainees are informed of their legal rights and can freely exercise these rights while in custody.

Respect

During our inspection, we found that custody personnel were always respectful towards detainees. They showed compassion during their interactions with them.

The booking-in areas in most suites offer limited privacy, despite some having privacy barriers to separate the booking-in desks. This is due to the close proximity of booking-in positions and the acoustics in these areas. The environment can be noisy when more than one detainee is booked in at the same time, and not many suites have a discrete booking-in room. However, detainees are routinely offered the opportunity to disclose confidential information to a member of custody personnel in private.

Most showers in the suites give privacy, but in some suites, the doors are too low. This means they aren't suitable for female detainees.

Custody officers usually ask female detainees if they would like to speak privately to a female member of custody personnel, as is good practice. But we didn't always see this reflected in the records. It wasn't clear whether female detainees were also assigned a female member of custody personnel to oversee their care.

There are signs telling detainees that CCTV operates in the suites, and custody officers remind them of this during booking-in. But in a few cells, the toilet area isn't sufficiently hidden from view on CCTV screens.

Area for improvement

The force should make sure facilities in the suites offer enough privacy to detainees, and that the toilet area in all cells is sufficiently hidden from view on CCTV screens.

Meeting diverse and individual needs

Custody personnel generally understand the needs of detainees from protected or minority groups, and they do their best to meet these needs. But the lack of facilities in suites can hinder their efforts.

Not all areas in custody are adapted well enough for detainees with mobility impairments. For example, not all suites have extra-thick mattresses, and there aren't many cells with higher benches. However, for detainees with visual impairments, there are adaptations such as sight lines in many cells. There is also provision for hearing-impaired detainees.

The force uses LanguageLine electronic tablets, which provide interpreting services for those who don't understand English. During our inspection, we saw detainees using these tablets. We found them to be noisy, and that they reduced privacy, especially when the booking-in area was busy.

Custody personnel we spoke to had a reasonable understanding of neurodivergent detainees' needs. However, when we asked personnel if they had received training in this area, some said they hadn't.

Some cells doors have glass panels. This helps manage risk, and it can also help detainees who suffer from claustrophobia. Custody personnel told us they generally placed children and vulnerable adults in cells near the booking-in area. This is positive.

During booking-in, custody officers routinely ask detainees whether they have caring responsibilities that need to be considered while they are in custody.

There is a good supply of hygiene products in all the suites. During booking-in, female detainees are asked if they need menstrual products.

Detainees can usually observe their faith, but there is an inconsistent range of religious texts in the suites. In some suites, there are more religious texts from some faiths than from others. We gave the force feedback on this matter and they immediately ordered new texts. Religious materials aren't always stored in a neat and respectful way.

Area for improvement

The force should:

- improve its facilities for detainees with mobility impairments; and
- store religious materials in a neat and respectful way.

Risk assessments

The force is generally good at identifying risk, but it is less good at managing ongoing risk. The force doesn't always follow APP guidance for risk management. This forms part of our cause of concern.

Waiting times for booking-in are generally short. But during busy periods, some detainees wait for long periods to be booked in, sometimes in police vehicles. This is a poor outcome for detainees, and it increases risk.

Although custody officers carry out risk assessments before detainees enter custody, this rarely results in children and vulnerable adults being prioritised for booking-in.

When completing an initial risk assessment, custody officers interact well with detainees and focus on identifying risk and vulnerabilities. They use [Police National Computer](#) information and previous custody records to inform their risk assessment. They only remove detainees' clothing when an individual risk assessment makes it necessary.

Custody officers supervise searches under section 54 of PACE, which allows them to see and list everything that a detainee has with them when they come into custody. But there is confusion over how extensive these searches should be. Custody officers told us they were hesitant to authorise searches beyond removing outer clothing. During our inspection, we saw several searches that weren't thorough enough to make sure the detainee didn't have anything on them that could cause harm.

The force has its own observation levels, which aren't consistent with APP. It doesn't use level 3 CCTV observations. This means its only options are level 4 constant observations or 30-minute checks, with nothing in between. This increases the risk to detainees.

Observation levels for detainees who show signs of intoxication aren't always set as level 2 with rousing checks. This is contrary to APP guidance. However, we saw detention officers rousing and interacting with detainees according to APP when detainees were placed on 30-minute checks with rousing.

Observation checks are generally timely and carried out well by the same detention officer. This helps bring about continuity of care. But we found that custody personnel didn't always record cell visits well.

The force doesn't have any anti-rip clothing. Anti-rip clothing should be used in exceptional circumstances, and it can help reduce and manage risk for the most vulnerable detainees. Not having this type of clothing means custody officers have fewer options for managing risk, as detainees can rip the clothing they are given. This can result in detainees spending long periods of time without suitable clothing.

The force has two ways of recording risk for handovers. Some suites use a shared spreadsheet on a storage platform called Box. But not all personnel have access to the spreadsheet, and the information isn't always transferred on to the force's IT system, Connect. Personnel in other suites record risk information for handovers on Connect, meaning the detainee's custody record is updated. Using two different methods has created inconsistency in the way the force records and manages risk.

During handovers, the custody officer going off duty briefs the incoming officer about detainees and their risks. The incoming custody officer then briefs the rest of the incoming team at 7am or 7pm. Handovers are generally recorded on CCTV, but we saw some taking place behind the custody control area, where there is no CCTV. This is contrary to APP.

Handovers include a comprehensive briefing about the risk associated with each detainee. However, there is limited information on the status of each investigation. This can have an impact on the way cases progress.

HCPs don't attend handovers. We saw some custody personnel who appeared to be disinterested. Some were looking at phones or unrelated material on computers.

Custody officers visit detainees at the start of their shift, and they check on their welfare. However, we were told that in one team, a detention officer always completed these visits. This is poor practice.

Key control is very poor, and there are no systems for booking keys in and out. Personnel at some suites didn't know how many sets of keys there were. We found that keys were often given to non-custody personnel without close monitoring. Most keys have large fobs or actual shoes attached to reduce the risk of them going missing, which has frequently happened.

Area for improvement

The force should improve its approach to risk management by:

- assessing the risk of detainees who are waiting to be booked in and prioritising the highest-risk detainees, as well as [children](#) and [vulnerable](#) adults;
- carrying out thorough and consistent searches under section 54 of the [Police and Criminal Evidence Act 1984](#) to minimise the risk of detainees having items that could cause harm;
- having a singular system for recording risk information for handovers;

- making sure all custody personnel attend handovers; and
- introducing an effective key-management system.

Individual legal rights – detention

In all the cases we observed and reviewed, custody officers appropriately authorised detention. They complete a thorough booking-in process, during which they consider detainees' needs. We saw some good examples of custody officers quickly establishing a rapport with detainees, considering their welfare, and taking account of their specific needs or vulnerabilities.

Some arresting officers have limited knowledge of the [PACE code G 2012](#) necessity criteria. We saw instances in which less experienced frontline officers couldn't provide the suitable necessity criteria for detention. In those cases, more experienced custody officers guided them. We also found that some frontline officers over-relied on using the 'prompt and effective' criterion, sometimes in the wrong circumstances.

The force uses alternatives to custody to avoid unnecessarily detaining people. We saw custody officers refusing detention, as well as making robust challenges to make sure detention was appropriate. In one instance, during the booking-in process, a custody officer had concerns about a detainee's mental health and decided that [voluntary attendance](#) was more appropriate than detention in custody. Custody officers have the full support of the custody senior leadership team when refusing detention, including children's detention.

Most detainees don't spend longer than necessary in custody. But we saw cases not being progressed. This means custody officers have to chase up interviewing teams to minimise the time detainees spend in custody. Several custody officers raised this as a problem.

Custody officers review [bail](#) conditions with investigating officers and appropriately authorise bail. They clearly explain bail conditions and restrictions to detainees, and the consequences of not adhering to them. For example, during our inspection, we saw a custody officer explaining bail conditions to a child who was being released, then testing the child to make sure they understood.

Area for improvement

The force should give frontline [officers](#) refresher training on the [Police and Criminal Evidence Act 1984 code G 2012](#) necessity criteria.

Individual legal rights – detainees’ rights and entitlements

Custody officers clearly explain legal rights and entitlements to detainees. In most cases, they make sure detainees can exercise them promptly. These include the right to:

- have someone informed of their arrest;
- consult a solicitor and access free independent legal advice; and
- consult the PACE codes of practice.

However, there aren’t enough hard copies of PACE code C in the custody suites. Paragraph 1.2 of PACE code C states: “This Code of Practice must be readily available at all police stations for consultation.” The force’s custody policy tells personnel to deal with detainees’ requests for a copy of PACE code C by printing it from the Government website.

We saw a member of custody personnel telling a detainee that they could have a copy, but the detainee didn’t receive one.

All detainees are offered a rights and entitlements leaflet, which contains a condensed version of PACE code C. Easy-read versions are also available for those who need them.

Posters in the custody suites advertise the right to free legal advice. These notices should be displayed in foreign languages as well as in English, but some suites only have them in English.

When detainees said they didn’t want a solicitor, we saw custody officers probing further and reminding them that this is free of charge. But during our audits, we found that when detainees refused a solicitor, the force didn’t always record whether personnel had asked the detainee why they didn’t want one.

The force uses LanguageLine interpreters for detainees who don’t understand English. During the booking-in process, portable tablets allow communication in most languages.

Custody officers we spoke to were aware of the requirements of PACE code C, annex M (documents and records to be translated). We saw personnel printing these documents in different languages and giving them to detainees, as is required.

Detainees can generally speak to their legal representatives in private. But during our observations, there was a faulty telephone at the Bromley suite, which meant that other people could hear conversations.

Custody officers contact embassies if foreign nationals ask them to do so. During our inspection, we saw this happening. Custody officers know the requirements of bilateral agreements.

Detainees who were held [incommunicado](#) had their rights delayed and reinstated as appropriate.

Not all custody personnel routinely tell detainees about the force's policy on retaining and disposing of DNA. In some suites, some information is displayed in the biometrics room to inform detainees about this policy, but the information isn't always clear.

Area for improvement

The force should strengthen its approach to legal rights by:

- having enough copies of the [Police and Criminal Evidence Act 1984 code C 2023](#) readily available in all suites;
- displaying information in different languages, in areas where detainees can clearly see it, about the right to legal advice;
- making sure that when they take samples, custody personnel consistently explain to detainees the force's policy on retaining and disposing of DNA, and displaying clear information about this policy in all custody suites, so detainees can understand their rights under the [Protection of Freedoms Act 2012](#).

Reviews of detention

Reviews of detention don't always comply with the requirements of PACE code C. Custody personnel don't always carry out reviews well enough, or in the detainees' best interests.

During our observations, some newly promoted and acting inspectors told us they had received little training or guidance, other than shadowing a custody inspector, on how to carry out a review. The force told us it provided this training, but some inspectors said they hadn't received any formal training on how to carry out reviews.

In our case audits and when we analysed custody logs, we found review entries that had been copied and pasted from a template. In some cases, the reviewing officers hadn't amended the text. This led to confusing and/or contradictory entries, which lacked detail, and didn't consider detainee welfare or the specific grounds for continued detention.

In our audits, we found five cases in which inspectors didn't carry out reviews in person as detainees were considered too violent. In each of these cases, officers had carried out level 4 constant observations and detention officers had completed routine cell checks.

In our audits and custody record analysis, we found that the proportion of sleeping reviews was higher than what we would expect to find in police forces in England and Wales. However, when we carried out observations in the suites, we found that the proportion of reviews carried out when the detainee was asleep was lower than what we found during our audits and analysis.

When reviews take place while detainees are asleep, they aren't always told about the reviews at the earliest opportunity. This is required by paragraph 15.7 of PACE code C. We saw an inspector leaving a detainee a note telling them that a review had taken place while they were asleep. But there was no record of any follow-up to find out if the detainee had understood the review or wanted to make any representations.

Custody inspectors are respectful and caring, and they communicate clearly with detainees when carrying out reviews. They consider detainees' welfare, particularly in relation to food and drink, but they rarely offer showers or reading materials. Reviews with foreign national detainees take place with interpreters. This is good practice.

In some cases, we found that inspectors authorised continued detention before asking if the detainee wanted to make any representations. And some inspectors didn't tell the detainee that they had authorised their continued detention.

There is a huge demand on custody support inspectors, who sometimes manage 2 custody suites, with a total of 70 to 80 cells. Due to the travelling time between suites, inspectors have to prioritise in-person reviews. The lack of resilience in inspector staffing levels means reviews aren't always carried out in detainees' best interests.

No custody inspectors are on duty between 5am and 7am. This means that reviews that are due at this time of day take place either early or late. This is contrary to PACE code C.

Reviews for children take place within one hour of a child's detention. We found that they were generally good, and that they thoroughly reviewed the progress of the case at an early stage in a child's detention.

Area for improvement

The force should make sure that reviews of detention follow the [Police and Criminal Evidence Act 1984 code C 2023](#) and are in the best interests of the detainee by:

- giving custody inspectors adequate training;
- improving the way reviewing [officers](#) record reviews on custody logs;
- carrying out sleeping reviews only when it is in the best interests of the detainee to do so;

- giving detainees the opportunity to make representations before deciding to authorise their continued detention; and
- telling all detainees who have a review while they were asleep that this has happened, and explaining decisions to authorise their continued detention.

Complaints

Information about how to make a complaint isn't well promoted in the suites. Some suites have posters, but the information isn't clearly visible to detainees in the booking-in areas and is only displayed in English. We found little evidence of custody personnel telling detainees about the complaints process.

All detainees receive a rights and entitlements leaflet, which outlines the complaints process. It says that detainees who wish to make a complaint should ask to speak to a police officer of at least the rank of inspector.

After release, they can make a complaint at any police station or to the [Independent Office for Police Conduct](#).

Custody personnel we spoke to gave mixed responses as to how they would deal with a detainee who wished to make a complaint. Some didn't know, and others believed that complaints should be dealt with outside custody.

During our inspection, we saw some detainees who wanted to make a complaint. Only one spoke to an inspector; others were instead given a leaflet. In some cases, we couldn't find evidence of any action being taken, and the custody records didn't show that the detainee wanted to make a complaint.

The force doesn't use custody complaints data to examine themes or identify where the complaints are taken – for example, in the custody suites or at police stations. Complaints aren't discussed at custody monthly performance meetings.

Area for improvement

The force should make sure all custody personnel know the complaints process, and it should better promote it in the suites.

Section 4. In the custody cell – safeguarding and healthcare

Expected outcomes

Detainees are held in a safe and clean environment, which protects their safety during custody. If force is used on a detainee this is as a last resort. Their care needs are met, and children and vulnerable adults are protected from harm. They have their physical and mental health, and any substance misuse, needs met.

Physical environment

The Metropolitan Police Service has 22 operational custody suites, as listed on the [fact page](#). It maintains the suites in a way that makes sure that the custody environment is safe, particularly the cells. We checked all suites, and we found some potential ligature points in the toilets in the Wandsworth suite, and in some door frames in the Peckham suite, but there were none in the cells. This is very good.

Custody personnel carry out daily safety and maintenance checks of the suites to a good standard. They understand what constitutes a potential ligature point. They told us that when repairs were needed, they were usually done quickly.

The communal areas in suites are generally clean, as are most cells. But some cell floors have heavy staining, particularly around the toilets (for example, in the Colindale, Wandsworth, Holborn, Bexleyheath, Islington, Holborn and Hammersmith suites). The communal areas in some suites need to be refurbished as they provide a poor physical environment for detainees and custody personnel (for example, in the Holborn, Bexleyheath and Islington suites).

Facilities for disabled detainees are poor. There were few examples of cells with adaptations, such as lowered call bells, higher benches, and adapted communal toilets and showers.

Most cells don't have sinks, which compromises hygiene standards and puts additional demand on detention officers, who have to take detainees out of their cells so they can wash their hands in communal sinks.

Most suites have some glass-fronted cell doors. This improves options for meeting detainees' needs and managing risk.

The standard of holding rooms is inconsistent. In some suites, detainees wait in a caged area outside the suite entrance. Some of these areas are on view to the police or public (for example, in the Charing Cross, Bethnal Green, Lewisham, Bexleyheath, Romford, Peckham and Stoke Newington suites).

Standards of exercise yards also vary. Some yards are cage-type facilities, which can be seen from police car parks, as well as surrounding buildings. Some suites (such as Holborn and Charing Cross) have no exercise yard at all, and others have yards that don't have any cover for use in bad weather.

CCTV coverage in suites is generally good, but some suites don't have cameras in all cells. This limits the options for custody personnel to manage risk. CCTV screens in the custody office areas vary significantly in size, and in the quality of images they display.

In general, CCTV signage adequately meets the requirements of PACE code C. But in some suites, there needs to be more signage, particularly in booking-in areas.

Most custody personnel we spoke to understood the emergency evacuation procedures. The force has provided some training in this area. But not all personnel we spoke to had taken part in full evacuation drills.

Area for improvement

The force should improve the physical environment of custody suites by:

- making sure all suites are clean and consistently decorated and refurbished;
- providing sufficiently private holding areas and exercise yard facilities at all suites, with cover for use in bad weather; and
- providing sinks in all cells to improve hygiene facilities for detainees.

Use of force

When force is used in custody, it is usually proportionate to the risk or threat. But the recording of incidents is sometimes poor and quality assurance is limited. As a result, it is difficult for the Metropolitan Police Service to show that when it uses force in custody, it is necessary, justified and proportionate.

We reviewed 61 custody records that involved 72 use of force incidents, and we viewed the CCTV footage of 64 incidents.

We saw that officers were patient and respectful towards detainees as they tried to de-escalate situations and avoid having to use force. In some cases, officers clearly recognised the potential risks to detainees. They used pillows to protect detainees' heads, and mattresses to prevent bodily injury. Officers also showed awareness of the risks of acute behavioural disturbance and positional asphyxia.

The Metropolitan Police Service uses an early risk assessment process, whereby a custody officer meets detainees when they arrive at custody. This process allows the force to move violent detainees into cells more quickly. It also means any use of force is less likely to be repeated.

Custody officers often record the time a detainee arrives in custody in handcuffs, leg restraints or spit hoods, but they don't record what time they remove those restraints. They also don't always record details of incidents in which they reapply and then remove restraints during the detention period.

We saw that when officers used equipment such as handcuffs, leg restraints and spit hoods, they made sure they properly applied them, and that they were regularly checked. But in two instances, detainees who had clothing removed were left in cells. One was wearing a spit hood, and in the other case, the spit hood was accidentally left in the cell with the detainee. This is poor.

When officers use force to put detainees in cells, most follow the nationally approved tactics for how officers should enter and leave cells.

Officers control violent detainees appropriately and safely, using unarmed tactics and restraints when necessary. Custody officers are present during most of these incidents, and they show good leadership by giving clear directions to keep officers and violent detainees safe.

However, we saw six cases in which custody officers weren't present during use of force incidents. In 4 of these cases, detainees stayed in restraints on close observations for periods lasting between 1 hour 25 minutes and 9 hours 37 minutes. The custody officer didn't visit the detainee during these periods. They also didn't update the custody records to show that they were managing and overseeing risk. In two of the four cases, the custody record didn't show that the detainee was in handcuffs, and it didn't cite the reason for continued restraint. This is required by paragraph 8.11 of PACE code C.

The recording of use of force incidents is inconsistent. In over half of the use of force incidents we reviewed, the recording of use of force was good and included detail that accurately reflected the incident. But 7 records lacked some information, 8 only showed the use of force reference number, and 17 contained no information about the use of force incident.

We reviewed 25 cases that involved strip searches authorised under section 54 of PACE. In all but two cases, we saw exceptional examples of custody officers appropriately authorising strip searches and recording their rationale. The records detailed the grounds for the search, the officers involved, the location and the result. Custody officers managed strip searches with compliant detainees well. To protect detainees' dignity, they carried them out in rooms without CCTV, rather than in cells.

In the cases we reviewed, custody officers clearly explained to detainees why a strip search was necessary and how they would carry it out. In some cases, this helped to de-escalate situations that involved violent detainees, and it allowed the officers to carry out the search safely.

Forces should record any removal of more than the detainee's outer clothing, including a clothes swap, as a strip search. This distinction was highlighted in the case of [Davies v CC Merseyside Police \[2015\] EWCA Civ 114](#). But not all custody officers record when they authorise the removal and replacement of a detainee's clothing. Under APP recommendations, they should do so. We reviewed 29 instances in which clothing was exchanged for custody clothing, but only 11 of these were recorded as having been authorised by a custody officer.

When officers use force to remove a detainee's clothing, it isn't always clear that the removal is necessary and justified. We saw some records that didn't show whether the officers had considered other options to manage the risk.

Officers don't always maintain detainees' dignity when removing clothing. We found that some intoxicated detainees were left naked or partially clothed, with custody clothing left for them to dress themselves with.

In the cases we examined, we found that some cells weren't covered by CCTV, which hindered our reviews. At the time of our inspection, the force was upgrading the CCTV in its custody suites.

Not all officers involved in use of force incidents fill in the required forms. In our review of CCTV footage, we heard some custody officers asking for the details of the officers involved. They reminded officers to submit use of force forms, as required by [National Police Chiefs' Council](#) guidance. We asked for the use of force forms relating to the incidents we reviewed. We were expecting 289, but we received 165.

Area for improvement

The force should improve the way it records and manages use of force incidents by making sure [custody officers](#):

- record all individual incidents in which force is used in custody;
- record when force is used on detainees in cells, including to prevent self-harm or when detainees are placed on constant observations;
- record when restraints are applied and removed from detainees;
- manage and record the continued need for keeping restraints on detainees in cells;
- record the grounds and authority for exchanging clothing due to risk, as per [authorised professional practice](#); and
- ensure [officers](#) who use force in custody submit individual use of force forms.

Detainee care

The approach to detainee care is good and custody personnel show a caring attitude towards detainees. Most detainees we spoke to said that they had been treated well while in custody.

During booking-in, custody officers tell detainees what provisions are available to them, such as exercise, showers, reading materials, and food and drink. They routinely give detainees a leaflet that lists these provisions. During our inspection, we saw some detainees using exercise yards, and some had reading materials. But in our audits, it wasn't always recorded whether detainees going to court were offered a shower.

Food and drink are offered and given regularly. There is provision for different diets, such as vegan, vegetarian and halal. Personnel in some suites told us that a rabbi brought kosher food.

There is an adequate range of reading materials in most suites, but there aren't enough foreign titles. In some suites, there are limited books for children.

The range of distraction materials is generally poor. Most suites have foam footballs, some have colouring books and a few have wobble boards. During our inspections of custody suites in England and Wales, we usually find more distraction materials.

Toilet paper isn't routinely provided in all suites. This is a poor outcome for detainees as asking for it can affect their dignity.

All cells have pillows and mattresses. But the mattresses are thin and some are worn. Only a few suites have extra-thick mattresses. Blankets are available and are usually routinely given when a detainee goes to their cell.

All suites have a good supply of replacement clothing in various sizes, including footwear. Male and female underwear is available. There is also a good supply of towels.

Area for improvement

The force should make sure:

- it has reading material in foreign languages for detainees who don't speak English; and
- it routinely gives toilet paper to detainees in all suites, rather than only when they ask for it.

Safeguarding children and vulnerable people

There is a strong focus on safeguarding detainees, especially children. Throughout our inspection, we saw custody personnel showing excellent awareness of individuals' vulnerabilities and taking steps to address them.

When they take up their posts, all custody personnel receive training on vulnerabilities (such as [child sexual exploitation](#)) and managing children in custody. Subsequent training events for all custody personnel reinforce this training. These events cover relevant topics, including the force's emerging child-first approach.

Rigorous arrangements are in place to monitor and safeguard children throughout their detention and beyond. The force expects custody officers to have a regular dialogue with investigating officers about any safeguarding concerns.

At an early stage in every detention of a child, custody personnel contact the relevant local authority to ask for and exchange information about the child. This means they can start arranging appropriate post-release support at the earliest stage.

Custody personnel also help to safeguard children by:

- referring them to youth offending teams;
- asking them child-specific risk assessment questions; and
- completing safeguarding assessments (which are also completed by arresting officers).

In most of the cases we reviewed, we found good evidence of custody personnel carrying out these actions. This shows the level of attention these issues are given by all those involved in managing detainees.

The force assigns both girls and boys a named officer to care for them during their time in custody. This is beyond the legal requirement (section 31 of the Children and Young Persons Act 1933), which states that girls under the age of 18 must be under the care of a woman while detained, while being conveyed to and from court, and while waiting to be conveyed to and from court. Our case reviews confirmed that this routinely happens.

Custody personnel who are allocated as carers understand how important it is to speak to the child in private, so they can introduce themselves and explain their role.

During our inspection, we saw custody personnel making sure that children were released safely. In our audits, we found that that custody officers clearly considered arrangements for the child to be safely escorted to an appropriate address. That may be with the help of arresting officers, family members or care home staff.

Less positively, even though the force's own custody policy requires it, not every child sees a non-policing professional, such as an L&D practitioner or an HCP. These services are available in all suites (although L&D services operate at specific times). It isn't clear why this doesn't consistently happen, but the force has recognised it as a problem and is committed to improving it.

Area for improvement

Every [child](#) in custody should see a non-policing professional, in line with the force's custody policy.

Appropriate adults

As part of the force's new child-first approach and its ambition to improve outcomes for children, it now expects custody personnel to request an appropriate adult (AA) within 45 minutes of a child being booked into custody. In the cases we reviewed, it wasn't clear whether the force always met this target, but personnel did request AAs in the early stages of detention. During our observations in the suites, we saw that custody personnel consistently contacted AAs early, within 45 minutes for both children and vulnerable adults. This is good.

As part of its recently introduced performance-monitoring measures, the force now regularly monitors how promptly it makes AA requests. This is a positive development.

In our case reviews and observations in suites, we saw that custody personnel paid attention to the needs and vulnerabilities of all detainees. They asked for AA support for all relevant adults.

As is standard practice in police custody, custody personnel first consider a person known to the detainee (a parent, relative, friend or a professional who they know) to provide AA support. However, when that isn't possible or suitable, alternative arrangements are available. The force told us that in these circumstances, local authorities were expected to provide AAs for children. It also said that agencies such as The Appropriate Adult Service and Appropriate Adults UK, which cover different parts of the force's area, could support vulnerable adults.

However, custody personnel from across the force told us that these partnership arrangements didn't always work, and that local authorities could rarely give the required support. Some custody personnel told us that The Appropriate Adult Service and Appropriate Adults UK generally provided a good service, but that this often depended on one or two people in those agencies, and that the provision of AAs wasn't always prompt, particularly at night.

During our inspection, we saw some instances of AAs attending quickly. We also saw some AAs supporting multiple detainees. However, we also saw that some detainees had long waits for AAs, and that AAs sometimes arrived at the time of the detainee's interview.

While the force has begun to gather information on how quickly it contacts AAs, it doesn't yet monitor how long it takes for AAs to arrive. This means it doesn't have an evidence-based understanding of the standard of service it provides across the force. This could help to inform the way it manages these partnership arrangements.

Area for improvement

The force should improve outcomes for detainees who need an [appropriate adult](#) by making sure those detainees receive prompt support. It should assess this by monitoring appropriate adult attendance times.

Children

The force clearly focuses on diverting children away from custody, when possible. The number of children detained in London has decreased in each of the past three years. This is positive.

Many of the custody officers we spoke to recognised that custody isn't always necessary or suitable for children. They could give recent examples of instances in which they had refused to authorise a child's detention as they considered alternative options more appropriate. In the cases we reviewed that involved detained children, we were satisfied that these decisions were appropriate.

Custody officers told us the force prioritised children for booking-in. But in our focus group discussions with frontline officers, it was clear they didn't consider this to be routine. And in our observations, we found no evidence to show any prioritisation.

The force told us that on average, children spent 14 hours 52 minutes in custody once they were detained. This is less time than the force average for adult detainees (19 hours 14 minutes), but it is a long time. The force would benefit from exploring the possible reasons for this.

As part of its efforts to improve outcomes for children, the force expects custody inspectors to carry out an early review of each child's case, so they can:

- make sure their detention is necessary;
- make sure certain actions (such as AA requests) have been carried out; and
- speak to the child.

We saw this routinely happening. This measure helps the force be sure that it appropriately detains children, and that important actions progress quickly.

At the time of our inspection, the force was trialling new child-first arrangements at two suites (Brixton and Wood Green), where extra measures were in place to give children a better experience in police custody. This was part of the Child First Custody Training and Research Pilot (ChiRP). As well as adopting a 12-hour (rather than 24-hour) custody timescale, children taken to these suites could access specially trained legal advisors, and bespoke cells, booking-in desks and interview rooms with more child-friendly decoration and furnishings. Custody personnel also scrutinised the progress of children's cases even more closely. This initiative is positive as it could result in children in these suites having a better experience.

However, at the time of our inspection, the force hadn't assessed any data or other information to inform its understanding of any impact the initiative could make. After our inspection, the force told us it had finished the pilot and was now reviewing its impact.

Less encouragingly, the situation for children who are charged and remanded into custody remains poor, with few children transferred to local authority accommodation. There has been little improvement in this area since our last inspections. In 2024, only two children detained by the force were moved into secure accommodation. In the same year, the force made 332 requests for appropriate non-secure accommodation, and 46 children were moved. Outcomes remain poor because local authorities lack the capacity and capability to provide suitable accommodation.

The force has good governance and oversight arrangements at both operational and strategic levels to monitor outcomes for children. This includes a monthly children in custody board and an internal inspection team that carries out dip samples.

Area for improvement

The force should reduce the length of time [children](#) spend in police custody, and it should work with partners to improve the outcomes for children charged and detained overnight in custody.

Healthcare

The Metropolitan Police Service directly employs HCPs to provide healthcare services to detainees. It allocates HCPs to each custody suite, and they provide healthcare cover 24 hours a day, 7 days a week. They offer a range of services to detainees, such as reviewing injuries, support in managing long-term conditions, administering medicines and managing withdrawal symptoms, as well as carrying out forensic sampling. They also carry out mental state assessments and give case management recommendations out of hours and when there are no L&D practitioners in the suite.

In accordance with the force's performance priorities, it started a five-year transformation programme in 2022 to make sure it meets detainees' needs and improves their outcomes. Managers monitor the progress, and the force is on track to make the required improvements by 2027.

The force has adequate strategic oversight of its health provision. It does this through an established framework of regular governance meetings, including the clinical governance committee, the L&D partnership board meeting, and the mental health urgent and emergency care operational group. Local meetings underpin these governance meetings. Area managers and senior HCPs also carry out projects to improve outcomes for detainees, including one on menopause care. This helps the force oversee the quality of the services it provides. It also allows both the force and its partner agencies to assess risk. This is positive.

Due to the functionality of the force's IT system, Connect, the force can't gather all relevant healthcare data. But in 2024, the force gathered data from both Connect and SystmOne (the system HCPs use to record clinical interventions and discussions with detainees). This meant managers could analyse enough data to identify and understand patient safety concerns, gaps in service provision and opportunities for development.

By using SystmOne alongside Connect, the force can now gather data on health response times, incidents and clinical audits. However, having to use both systems creates more work. The force is developing an app that will help HCPs record their daily checks and audits electronically. This sort of digital innovation should help the force gather more accurate data.

Data extraction from Connect in relation to MHA assessments and the use of section 136 of the MHA in custody remains poor. The force can't identify how often it uses section 136, or how long detainees spend in custody while waiting for an MHA assessment and/or transfer to a mental health bed or a health-based place of safety. This means outcomes for detainees subject to these processes aren't clear.

Healthcare staff receive appropriate mandatory training. The force makes a substantial financial contribution to help staff access professional development opportunities. For example, it works with the University of Greenwich to provide a postgraduate course in advanced forensic practice, and it supports student nurses in their training. This helps to promote the profile of such a specialist area of nursing.

The force also has 12 non-medical prescribers, who provide cover 24 hours a day, 7 days a week. This means custody personnel don't have to rely on forensic medical examiners to prescribe medicines.

All healthcare staff can access a telephone interpreting service for detainees who don't understand English.

At the time of our inspection, the force had recently recruited more HCPs. This means HCPs don't have to cover more than one suite as often as they used to.

The force expects that 80 percent of detainees are seen by an HCP within 2 hours, and within 1 hour in urgent cases. We found that it met this expectation. Custody personnel told us that HCPs responded promptly to requests to visit detainees. They also said HCPs prioritised more urgent situations and managed their workload effectively.

The force has a procedure that tells custody personnel how to manage evidential samples in fridges and freezers on a daily basis, including storing and retaining them. But in practice, the management of samples is inadequate. Custody personnel don't complete the required daily checks, and samples aren't always collected. At the Bexleyheath suite, we found one sample dating back to 21 November 2023.

HCPs report incidents through the force's reporting system. Managers investigate these incidents, and they share learning with staff by email and through a monthly healthcare bulletin. The clinical governance committee oversees any themes or trends.

The force hasn't received many healthcare-related complaints. However, this could be because information about how to make a complaint isn't displayed in all medical rooms.

Area for improvement

The force needs to improve the way it manages evidential samples in fridges and freezers by carrying out daily checks and making sure samples are collected for analysis.

Physical health

HCPs offer a range of services to detainees, such as reviewing injuries, support in managing long-term conditions (such as asthma and diabetes), administering medicines and managing withdrawal symptoms. There is a procedure to guide staff to help detainees who are breastfeeding. Some custody suites have breast pumps, and in suites without them, staff can request them from another suite.

Detainees receive prompt clinical assessment from experienced and competent HCPs. Senior HCPs are available every day to support the service and can cover any staff shortages in the rota. Area managers provide senior leadership support 24 hours a day. Staff told us they enjoyed their role and felt extremely well supported through regular clinical supervision and an annual performance review.

Custody personnel we spoke to were very complimentary about the embedded HCP model in the custody suites. They reported positive and supportive working relationships, and they clearly valued the HCP role.

Custody personnel offer all detainees the opportunity to see an HCP. When detainees need to see an HCP, custody personnel log a request via Connect. HCPs regularly monitor the dashboard to check for new referrals, and they make sure they respond promptly. They clinically triage referrals and prioritise assessment according to clinical need.

Each custody suite has a well-equipped clinical room, which is used solely by HCPs. HCPs regularly check emergency equipment, and custody personnel check first aid kits and automated external defibrillators. We saw that HCPs kept records that confirmed when checks had been completed, although there were some gaps.

Compliance with infection control guidelines isn't good enough. We found limescale on taps and sinks, and on clinical flooring. Several examination couches showed signs of wear and tear. However, the force told us that a programme to refurbish clinical rooms had started.

HCPs use SystmOne to record clinical interventions and discussions with detainees. They can use it to access detainees' community summary care records, subject to gaining consent from the detainee. Using SystmOne also allows onward information sharing with healthcare staff in courts and prisons.

HCPs record an appropriate level of information in the custody record. They also contribute to decisions about risk, fitness to detain or release, and fitness for interview.

There is limited privacy for detainees, as many healthcare consultations take place with the door open. This is poor, and custody personnel can hear discussions. Staff told us that in some suites, regardless of whether or not there was a risk, a detention officer stayed nearby. HCPs take intimate samples with the door closed, but a police officer is present in the room. HCPs told us the officer faced away from the examination couch. There are no privacy screens in any of the clinical rooms.

Area for improvement

In order to maintain detainees' dignity and privacy in custody suites, the force should make sure:

- privacy screens or curtains are available, particularly for the collection of intimate samples; and
- that the door is always closed during healthcare consultations, subject to an individual [risk assessment](#).

Mental health

Innovative practice: Specialist youth practitioners work as part of the ENGAGE and DIVERT programmes to make sure children and young people receive additional support

The force has specialist youth practitioners who work as part of the [ENGAGE](#) and [DIVERT](#) programmes. They are integrated into its custody services to support young people during a time of crisis.

The ENGAGE programme is a custody-based intervention for under 18s. It is a partnership between the force, local authority children's services and NHS England. It helps [children](#) who have been arrested for violent offences to access statutory services and reduce the risk of reoffending. The force and these partner organisations work with the children to provide ongoing, long-term support and guidance that can lead to education, training, apprenticeship and employment opportunities.

The DIVERT programme supports young people aged 18–25. Custody intervention coaches, who are independent of the police investigation, provide help with education, training and employment.

The data we received from the force shows encouraging outcomes for the children and young people who have received support from these programmes.

NHS England commissions nine organisations to provide services to detainees. These cover all types of vulnerabilities, including those relating to social needs and health. Partnership arrangements between the organisations are good, and NHS England provides adequate oversight.

L&D teams across London work varying hours, but they are generally in custody suites for eight to ten hours during the daytime. Some teams have vacancies, and this means they can't always see every detainee. Staff prioritise detainees according to need, and we saw them working hard to see as many detainees as possible.

L&D practitioners complete thorough assessments, which take into account mental health and other vulnerabilities, such as homelessness. They make onward referrals to [Together for Mental Wellbeing](#), which provides community link workers and peer support based on individuals' needs for up to three months.

Custody personnel make appropriate referrals to either the L&D team or an HCP. L&D teams can't access the custody record system, which means they can't always identify detainees who may benefit from seeing them, particularly when people use alias names. But the teams work hard to overcome this problem by regularly communicating with custody personnel, and by handing over relevant information at the start of each day. L&D practitioners share the detainee's summary with custody

personnel, so they can add it to the police records. They also record any concerns or risks on the digital person escort record.

Not all custody suites have confidential areas that L&D practitioners can use to speak to detainees. Some practitioners speak to detainees in their cells.

For detainees with both mental health and substance misuse problems, we saw good joint working between L&D practitioners and HCPs, as they carried out joint assessments. Substance misuse services in the community take referrals from HCPs, and L&D teams and can come into some custody suites to see detainees before they are released.

There is an agreed process for custody personnel and other staff to follow when there are concerns about a detainee's mental health, and all staff are aware of this. During working hours, L&D teams contact an approved mental health professional (AMHP) to request an MHA assessment in custody. Out of hours, HCPs do this.

In the force's geographical area, there 32 local authorities, and each has different arrangements for providing out-of-hours mental health services. We received mixed feedback about the timeliness of MHA assessments. Some custody personnel told us that AMHPs attended within a few hours, but others told us it took longer. Custody personnel also said that AMHP response times were longer in the evenings and overnight. Some local authorities confirmed to us that there was a shortage of AMHPs, and of doctors approved under section 12 of the MHA to complete MHA assessments.

Custody personnel told us there were often long waits for suitable beds for detainees who needed hospital admission after MHA assessments. The force couldn't give us data on the number of MHA assessments carried out in custody, or on the time detainees spend in custody while they wait for an MHA assessment or transfer to a local bed. L&D providers gave us some data, but the different providers collect different data, so the data collected isn't consistent. As a result, it isn't possible to accurately assess outcomes for detainees.

In February 2025, NHS England, in partnership with the force and L&D providers, introduced an initiative to remove the need to carry out MHA assessments in custody. At the time of our inspection, this initiative was still under review, and we were not able to comment on it.

The force's use of section 136 of the MHA to detain a person in the community and take them to a mental health facility is similar to that of other forces in England and Wales. In the 12 months before our inspection, the force used section 136 on 1,510 occasions. Frontline officers have access to support for dealing with people with mental health conditions. This includes access to mental health liaison officers, a mental health clinical advice line and a mental health app. In some areas, officers have access to mental health [street triage](#) teams, but this isn't consistent.

The force uses section 136 powers to remove detainees from custody to a health-based place of safety if it is clear there will be a long wait for a mental health assessment. There are only 31 beds available across the force's geographical area, and personnel told us these beds were often full. This means officers have to take detainees to accident and emergency to wait for an assessment. This is a poor outcome for detainees and a poor use of police time.

Some custody personnel told us they hadn't received any mental health training. Others told us they had received a small amount of training, mainly during their inductions. Many L&D providers told us they had offered to give mental health training, and that they had given it in some custody suites. When we spoke to custody personnel, they told us they would welcome more mental health training.

Area for improvement

The force should make sure it arranges access to Connect for [liaison and diversion](#) practitioners.

Substance misuse

In most cases, HCPs promptly review detainees with substance misuse problems, using a recognised clinical assessment tool. If necessary, medicines are prescribed and administered at appropriate intervals to manage withdrawal symptoms. HCPs continue to monitor and review these detainees at regular intervals.

Detainees who receive methadone in the community can continue to receive it in custody, subject to an HCP verifying this with the detainee's pharmacy. For detainees who receive this treatment, an officer collects the medication from the pharmacy, so it can be given in custody.

Across London, various arrangements are in place for substance misuse services to support detainees post-custody. In some suites, we saw a substance misuse practitioner attend custody to carry out an assessment. This takes place after a referral by L&D teams or an HCP. In other cases, referrals are made for the detainee to attend an appointment in the community. In Bethnal Green, substance misuse practitioners work at the station, covering both courts and custody.

The force automatically carries out drug tests for detainees who are arrested for specific offences. This is to reduce drug-related offending. As a result, detainees can access community drug services for support and treatment, as well as a drug education programme.

Medicines management

HCPs can give detainees medicines after assessment and in line with the force's patient group directions. The HCP team has access to a good range of prescribers, 24 hours a day. This means delays in obtaining medication prescriptions are minimal.

HCPs check controlled drugs every day, and they confirm the balance in the controlled drugs register. We found that in all suites, controlled drugs were stored in a locked cabinet. In most suites, this cupboard was covered by CCTV. In one of the contingency suites, we found expired controlled drugs, which should have been collected several months beforehand. These drugs had been deducted from the register, despite remaining in the cabinet. We raised this problem with the force and it took action to address it.

When HCPs give detainees medicines, they record it the detainee's clinical record in SystmOne. But the force doesn't keep a central record of which medicines are taken out of the general medicines cabinet. HCPs couldn't say how many of each medicine there should be, including rectal diazepam. This causes a risk to the force. After we highlighted this problem to the force, it started to reviewing the procedure. This is positive.

The force doesn't keep a record of room temperatures in the clinical rooms, and not all these rooms have a thermometer. This means there is a risk of medicines being stored at temperatures exceeding the manufacturer's recommended maximum, which could affect their efficacy.

HCPs and custody personnel work together to make sure detainees who are prescribed medicines in the community continue to receive them while in custody. This includes detainees' own labelled medicines and opiate substitute treatment. Custody personnel can give detainees nicotine replacement therapy if they need it.

Records of medicines given in custody are available to community services after release or transfer from custody.

Area for improvement

The force should make sure it:

- keeps an accurate record of all medicines given to detainees in custody; and
- monitors and records the temperature in clinical rooms.

Section 5. Release and transfer from custody

Expected outcomes

Detainees are released or transferred from custody safely. Those due to appear in court in person or by video do so promptly.

Safe release and transfer arrangements

The force doesn't always release detainees safely. Not all pre-release risk assessments contain enough detail to show how the force has identified and addressed risks such as self-harm.

Custody officers don't always carry out pre-release risk assessments in the presence of the detainee. They rely on a standard question set, which means they don't always ask detainees the relevant questions, or further probing questions, to assess the risk. The quality of pre-release risk assessments and the fact that the force doesn't always carry them out with the detainee present form part of our cause of concern.

We saw that detainees who had been arrested for sexual offences were asked supplementary questions and given enhanced support on leaving custody. Custody officers showed sensitivity and awareness of risk when managing the release of these detainees.

Custody officers give detainees a leaflet about support services available to them on release. But they don't always explain these services to detainees, and we found that the leaflet was out of date.

Custody officers explain bail conditions well, and the process of being [released under investigation](#). They explain to detainees the consequences of breaching bail conditions. For those who are released under investigation, custody officers explain the offences they may commit if they interfere with witnesses.

Detention officers complete the digital person record and arrange transport for detainees who are attending court or being recalled to prison. They complete these records well, and they include the relevant risk, health and medical information. Custody officers oversee this process, but they don't routinely speak to detainees leaving custody in these circumstances to carry out a pre-release risk assessment. This practice doesn't follow APP guidance.

Area for improvement

The force should update the support leaflet it gives to detainees who are being released.

Courts

Detainees are dressed appropriately when they are released from custody to attend court.

The force's transport contractor can't always promptly collect remanded detainees to take them to court. Sometimes, the courts don't have capacity to see all remanded detainees, and on some days, particularly Mondays, there are substantial gaps in court capacity. This means some detainees spend up to 48 hours longer in police custody than they should. This is a poor outcome for detainees, and it places extra pressure on police custody suites.

Area for improvement

The force should continue working with court services and the transport contractor to minimise the length of time detainees stay in police custody after being remanded.

Section 6. Summary of cause of concern, recommendation and areas for improvement

Cause of concern and recommendation

Cause of concern

The force doesn't oversee a wide enough range of custody services to make sure it can protect the safety and well-being of detainees, and improve the outcomes for those with mental health conditions.

Recommendation

With immediate effect, the force should strengthen its governance of custody and its quality assurance process. It should:

- further develop the way it scrutinises use of force incidents to include comprehensively auditing records and reviewing CCTV footage;
- make sure all custody personnel follow [authorised professional practice \(APP\)](#) guidance on managing risk, particularly for detainees under the influence of alcohol or drugs, and that pre-release [risk assessments](#) are thorough and completed with the detainee present;
- make sure all [personnel](#) follow the [Police and Criminal Evidence Act 1984 \(PACE\)](#) and its codes of practice, particularly when carrying out reviews of detention under section 40 of the Act;
- develop processes for comprehensively auditing custody records to include qualitative aspects of performance; and
- gather and monitor data to make sure it understands the way it uses section 136 of the [Mental Health Act 1983](#) in custody, as well as waiting times for mental health assessments.

Areas for improvement

First point of contact

The force should improve support for frontline [officers](#) by making sure:

- frontline officers have access to timely and good-quality information to help them respond to incidents and make appropriate decisions; and
- advice and assistance from mental health professionals is consistently available to officers across the force, to help them when dealing with people with mental health conditions.

In the custody suite – booking-in, individual needs and legal rights

The force should make sure facilities in the suites offer enough privacy to detainees, and that the toilet area in all cells is sufficiently hidden from view on CCTV screens.

The force should:

- improve its facilities for detainees with mobility impairments; and
- store religious materials in a neat and respectful way.

The force should improve its approach to risk management by:

- assessing the risk of detainees who are waiting to be booked in and prioritising the highest-risk detainees, as well as [children](#) and [vulnerable](#) adults;
- carrying out thorough and consistent searches under section 54 of the [Police and Criminal Evidence Act 1984](#) to minimise the risk of detainees having items that could cause harm;
- having a singular system for recording risk information for handovers;
- making sure all custody personnel attend handovers; and
- introducing an effective key-management system.

The force should give frontline [officers](#) refresher training on the [Police and Criminal Evidence Act 1984 code G 2012](#) necessity criteria.

The force should strengthen its approach to legal rights by:

- having enough copies of the [Police and Criminal Evidence Act 1984 code C 2023](#) readily available in all suites;
- displaying information in different languages, in areas where detainees can clearly see it, about the right to legal advice;
- making sure that when they take samples, custody personnel consistently explain to detainees the force's policy on retaining and disposing of DNA, and displaying clear information about this policy in all custody suites, so detainees can understand their rights under the [Protection of Freedoms Act 2012](#).

The force should make sure that reviews of detention follow the [Police and Criminal Evidence Act 1984 code C 2023](#) and are in the best interests of the detainee by:

- giving custody inspectors adequate training;
- improving the way reviewing [officers](#) record reviews on custody logs;
- carrying out sleeping reviews only when it is in the best interests of the detainee to do so;
- giving detainees the opportunity to make representations before deciding to authorise their continued detention; and
- telling all detainees who have a review while they were asleep that this has happened, and explaining decisions to authorise their continued detention.

The force should make sure all custody personnel know the complaints process, and it should better promote it in the suites.

In the custody cell – safeguarding and healthcare

The force should improve the physical environment of custody suites by:

- making sure all suites are clean and consistently decorated and refurbished;
- providing sufficiently private holding areas and exercise yard facilities at all suites, with cover for use in bad weather; and
- providing sinks in all cells to improve hygiene facilities for detainees.

The force should improve the way it records and manages use of force incidents by making sure [custody officers](#):

- record all individual incidents in which force is used in custody;
- record when force is used on detainees in cells, including to prevent self-harm or when detainees are placed on constant observations;
- record when restraints are applied and removed from detainees;
- manage and record the continued need for keeping restraints on detainees in cells;
- record the grounds and authority for exchanging clothing due to risk, as per [authorised professional practice](#); and
- ensure [officers](#) who use force in custody submit individual use of force forms.

The force should make sure:

- it has reading material in foreign languages for detainees who don't speak English; and
- it routinely gives toilet paper to detainees in all suites, rather than only when they ask for it.

Every [child](#) in custody should see a non-policing professional, in line with the force's custody policy.

The force should improve outcomes for detainees who need an [appropriate adult](#) by making sure those detainees receive prompt support. It should assess this by monitoring appropriate adult attendance times.

The force should reduce the length of time [children](#) spend in police custody, and it should work with partners to improve the outcomes for children charged and detained overnight in custody.

The force needs to improve the way it manages evidential samples in fridges and freezers by carrying out daily checks and making sure samples are collected for analysis.

In order to maintain detainees' dignity and privacy in custody suites, the force should make sure:

- privacy screens or curtains are available, particularly for the collection of intimate samples; and
- that the door is always closed during healthcare consultations, subject to an individual [risk assessment](#).

The force should make sure it arranges access to Connect for [liaison and diversion](#) practitioners.

The force should make sure it:

- keeps an accurate record of all medicines given to detainees in custody; and
- monitors and records the temperature in clinical rooms.

Release and transfer from custody

The force should update the support leaflet it gives to detainees who are being released.

The force should continue working with court services and the transport contractor to minimise the length of time detainees stay in police custody after being remanded.

Section 7. Appendices

Appendix I – Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and throughout their time in custody to their release. We visit the force over two weeks. Our methodology includes the following elements, which inform our assessments against the criteria set out in our [‘Expectations for police custody’](#).

Document review

Forces are asked to provide various important documents for us to review. These include:

- the custody policy and/or any supporting policies, such as the use of force;
- health provision policies;
- joint protocols with local authorities;
- staff training information, including officer safety training;
- minutes of any strategic and operational meetings for custody;
- partnership meeting minutes;
- equality action plans;
- complaints relating to custody in the six months before the inspection; and
- performance management information.

We also request important documents, including performance data, from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template based on police custody data for the previous 36 months. The template requests a range of information, including:

- custody population and throughput;
- the number of voluntary attendees;
- the average time in detention;

- children; and
- detainees with mental health problems.

This information is analysed and used to provide background information and to help assess how well the force performs against some main areas of activity.

Custody record analysis

We analyse a sample of custody records drawn from all detainees entering custody over a one-week period prior to the start of our inspection. The records are stratified to reflect throughput at each custody suite and are then picked at random. Our analysis focuses on the legal rights and treatment and conditions of the detainee.

Case audits

We audit around 40 case records in detail (the number may increase depending on the size and throughput of the force inspected). We do this to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include examining records for children, individuals with mental health problems, those under the influence of drugs and/or alcohol, and cases where force has been used on a detainee.

Our audits examine a range of factors to assess how well detainees are treated and cared for in custody. Audits examine, for example, the quality of risk assessments, whether observation levels are met, the quality and timing of PACE reviews, whether children and vulnerable adults get support from appropriate adults when they need it, and whether detainees are released safely. We also assess whether force used against a detainee is proportionate and justified, and is properly recorded.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing their physical conditions, observing operational practices, and assessing how detainees are treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first-hand. We also speak to other non-custody police officers, solicitors, health professionals and other visitors to custody to get their views on how custody services operate. We examine custody records and other relevant documents held in the custody suite to assess how detainees are dealt with, and whether policies and procedures are followed.

Interviews with personnel

During the inspection we interview officers from the force. These include:

- chief officers responsible for custody;
- custody inspectors; and
- officers with lead responsibility for areas such as mental health or equality and diversity.

We speak to people involved in commissioning and running health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak to the co-ordinator for the Independent Custody Visitor scheme for the force.

Focus groups

During the inspection we hold focus groups with frontline response officers and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

Feedback to force

The inspection team provides an initial outline assessment to the force at the end of the inspection, to give it the opportunity to understand and address any concerns at the earliest opportunity. Then we publish our report within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit about one year after our inspection to assess progress against our recommendations.

Appendix II – Inspection team

- Ian Smith: HMICFRS inspection lead
- Justine Wilson: HMICFRS inspection officer
- Anthony Davies: HMICFRS inspection officer
- Sarah Hamilton: HMICFRS inspection officer
- Emmanuelle Versmessen: HMICFRS inspection officer
- Stephen Matthews: HMICFRS inspection officer
- John Allen: HMICFRS inspection officer
- Ramzan Mohayuddin: HMICFRS inspection officer
- Joanne White: CQC inspector
- Catherine Raycraft: CQC inspector
- Bev Gray: CQC inspector
- Matthew Tedstone: CQC inspector

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