Custody Independent Scrutiny Panel: Vulnerable Detainees

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Police and Crime Commissioner for Dyfed-Powys
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Contents

Overview, Background, Purpose and Methodology

The origins, purpose and the rationale for the Custody Independent Scrutiny Panel (CISP) can be found on our webpage and specifically under the Terms of Reference (ToR) via this link: Dyfed-Powys Police & Crime Commissioner

The CISP will be looking at topics from the previous year on a cyclical basis with the purpose to compare and assess whether learning identified has been implemented within custody services.

Last year, the CISP focussed on Anti-Harm Suits (AHS) also known as Anti-Rip clothing and/or Special Risk Clothing. In preparation of acquiring the custody records for this CISP, there had been no AHS provided to any detainee in Dyfed-Powys; therefore, the decision was made to focus on vulnerable detainees.

Vulnerability can be difficult to define based on different legislation and guidance including:

- College's Vulnerability Assessment Framework
- Capacity Assessment (Mental Capacity Act 2005)
- Need for assessment (Mental Health Act 1983)
- Reasonable adjustments (Equality Act 2010)
- Fitness for interview (PACE Code C Annex G)

The appropriate adult network has a series of videos focussed on the concept of a 'vulnerable person' based on the Police and Criminal Evidence (PACE) Act 1984.

PACE defines vulnerability under Code C 1.13 as:

'vulnerable' applies to any person who, because of a mental health condition or mental disorder (see Notes 1G and 1GB):

- *may have difficulty understanding or communicating effectively about the full implications for them of any procedures and processes*
- *(ii) does not appear to understand the significance of what they are told, of questions they are asked or of their replies:*
- *(iii) appears to be particularly prone to:*
    - *becoming confused and unclear about their position;*
    - *providing unreliable, misleading or incriminating information without knowing or wishing to do so;*
    - *accepting or acting on suggestions from others without consciously knowing or wishing to do so; or*
    - *readily agreeing to suggestions or proposals without any protest or question.*

An Appropriate Adult (AA) are there to support vulnerable people from giving unreliable evidence. Unreliable evidence leads to miscarriages of justice and failed prosecutions.

The Panel were provided with additional questions for this scrutiny panel which include:

- What was the necessity for the arrest?
- Define what was noted by custody staff for specifying that the detainee was vulnerable.
- What was the disposal method?

Here is an example of the set of questions the Panel were asked to consider:

Summary of Findings

Below is a summary of some of the findings by the Panel:

Positives:

Treatment of Vulnerable DPs
Overall, the Panel assessed 53% of records reviewed showed that Detained Persons (DPs) were treated well by custody staff and noted how well they were handled despite the complex needs of some of the DPs.

Rights and Entitlement
All DPs were given their rights either at booking in stage or at a later stage during their detention.

Observation Level
The Panel recorded 95% confirmation that DPs risks were taken into account with only one record where the Panel member could not find the detail. (*Please see Force observations for further details on the record that was assessed as risks not taken into account*).

Support Services

Given the proportion of vulnerability within DPs was identified as MH issues with 31%, 53% of DPs were offered support services in comparison to 37% who were not and 10% that this was not applicable.

Strip Search
Of the 19 records, only 6 were strip searched; of which the Panel noted that 5 of those had a good rationale for being conducted. (*Please see Force observations for further details on the record that was deemed inappropriate*).

Anti-Harm Suits/Special Risk Clothing (SRC)
Of the 19 custody records reviewed, no detainee was provided with SRC and no clothing was removed by force.

Areas for improvement:

Gaps in recording information

Gaps in recording of the rationale recording delays or attendance from the AA or legal representatives was prevalent within many of the records. There was also limited to no detail in relation to the recording of the DP's religious beliefs, whether religious items were offered and whether the DP was instructed regarding the cell call bell or that the toilet was pixelated.

Appropriate Adult (AA)

The average time for a detention officer to make contact with AA was 7 hours and 30 minutes, and the average time the DP first made contact with an AA was 8 hours and 10 minutes.

Healthcare Professionals (HCP)

Of the 14 DPs that were required to see a HCP, 5 experienced delays. (*Please see Force observations for further details*).

Female Detainees

The Panel specified that the record was unclear on two occasions if a female officer had been available; and in another record, a Panel member specified that the topics surrounding pregnancy and hygiene were recorded as 'Not Applicable'. Within 5 records, the Panel could not determine if Hygiene (showers or handwashing facilities) had been offered or requested by the DP.

Panel Observations

Force comments were produced by an Inspector of Custody Services for Dyfed-Powys Police.

Theme	Observation	Force Response
Vulnerability	There were 3 records whereby the Panel could not determine why the DP was considered vulnerable. Could you provide some clarity in relation these? In one instance, the DP demonstrated that they were not vulnerable on the basis that they could read and write and demonstrated that they had capacity based on their occupation. Can you provide some clarification why this DP was considered vulnerable as part of this dip sample?	*The reasons the 3 records were identified as vulnerable are:* - *Diagnosed with depression, anxiety, ADHD, and autism.* - *Diagnosed with depression, ADHD and recovering alcoholic* - *Diagnosed with fibromyalgia and suffers with brain fog* *From reviewing this record, the DP did not require an AA, but was listed as vulnerable as diagnosed with anxiety, depression, and ADHD.*
Appropriate Adult	1. Given that the focus is on Vulnerable Adults, do you consider the average time for custody to contact an AA being 7 hours and 30 minutes, with the longest period identified being 19 hours, to be proportionate? 2. The Panel noted that on one occasion an AA was not provided due to the DP appearing to have capacity;	1. *No, I do not consider this to be proportionate. This is an issue that this CISP has highlighted. When considering children in custody, AAs are contacted immediately, but there does not appear to be the same level of urgency with regard to adult detainees when they require an AA. This is an issue that is currently being explored further and improvements will need to be made.*

	however, required an AA on a previous occasion in custody. Can you advise if this is appropriate? 3. There was no evidence in the risk assessment or specification of the individual being assessed as vulnerable or having MH needs. There was also no explanation provided for why an AA was later contacted 11 hrs into custody to accompany to interview. Can you provide clarification on this? 4. Another record shows that the AA was not contacted 7 hours 25 minutes after detention was authorised. Can you advise if this correct; and if so, would this be considered to be proportionate? 5. There were a further two records where information was absent in the record for the delay in the AA arriving. Can you advise why a delay occurred and whether custody staff could do anything to reduce the delay?	2. *On review of this record, the custody officer highlights within the care plan that the DP appears to have capacity but had an AA on a previous custody visit. Due to this, the HCP was asked to conduct a fitness to interview and in the HCP's professional opinion the DP did not require an AA. I would suggest that this was proportionate under the circumstances as a person's level of capacity, or lack of, can alter depending on treatment received etc.* 3. *On review of this custody record the initial risk assessment completed with the DP only highlighted that he suffered with fibromyalgia and mild scoliosis. However, the DP later disclosed symptoms similar to Gulf War Disease which meant he suffered from brain fog symptoms. Due to this, the decision was made to provide the DP with an AA for support during interview.*

		4. *DP was arrested during the early hours of the morning, required hospital treatment, and did not arrive at custody until 0312hrs. Due to this, the DP would have required a period of rest after being seen by HCP for fitness to detain. AA was then contacted after period of rest was complete and this allowed for processing and interview to take place. I would suggest that this was appropriate.* 5. *The first record the DP arrived during early hours and required a rest period. However I would suggest that the AA should have been contacted earlier in the second record. The delay appeared to be due to outstanding enquiries needing to be completed by the investigating officers and AA could have been contacted to provide support during that time. The DP had numerous vulnerabilities, and whilst the level of care provided by custody staff was good, an AA earlier would have been beneficial.*

Observation level	1. One Panel member could not find details in relation to the observational level within their custody record. 2. Another Panel member specified that their record did not appear to adhere to the Observation level 2 set for the DP.	1. *The observation is always recorded on the care plan, underneath the endorsement by the custody officer. The observation level was Level 1 observations 30-minute intervals.* 2. *The DP was on Level 2 rousing checks from 22:39hrs – 01:16hrs when then changed to Level 1 30 observations. Custody staff completed 8 checks in total during that time period, and all checks adhered to the Level 2 30 observation level with the DP roused and spoken to within the 30-minute check time. I am unsure whether the panel member noted the change in observation levels to Level 1, meaning rousing was no longer required, and this may have caused confusion.*
Strip Search	1. One Panel noted that there was not a good rationale for a strip search to have been conducted. The rationale provided was that the DP had been arrested on suspicion of supply of drugs. DP had already been to hospital and scanned in case he had swallowed any item, and bowel	1. *On reviewing this record, I agree that the rationale contains very limited detail and feedback will be provided to the officer in question. This may have already been completed as all strip searches are audited during monthly auditing process. The strip search would*

	movements were monitored via the glass toilet; therefore, uncertain why a strip search was necessary. Could you provide an explanation? 2. A Panel member noted that there is a lack of information on the record to determine rationale for strip search, why AA identified was required but not contacted until much later, no record of solicitor being contacted and what appears to be a record relating to possibly another case referencing a Domestic Violence Protection Notice (DVPN) for an offence of theft with no clear connection to the offence being domestic related. Would you be able to provide some clarity or context to this?	*still have been necessary and proportionate as the scan at hospital only checks for any items that would have already been consumed or "packed" internally by the DP and would not account for any items that may be concealed within underwear etc.* *2. This record would have been complex for the panel member to review with information from various sources. I agree with the observation by the panel member that the rationale for the strip search lacked detail. The only rationale I can locate for the strip search is one line in the first care plan which states that the DP will be strip searched to ensure his safety whilst in custody. This is not sufficient to evidence the need to complete a strip search and feedback will be provided to the officer in question, if not already completed. The DP disclosed ongoing mental health issues including bi-polar, was diagnosed with ADHD and autism, and was dependent on alcohol and drugs. Due to this, AA was deemed to be required. The reason that there was a*

		delay in an AA being contacted is that the DP was under the influence of alcohol/drugs and was not fit to be processed or interviewed until several hours after arrival. I can confirm that a solicitor was contacted 21:53hrs, which was 8 hours after arrival at custody, but again this delay was caused by the DP being under the influence of alcohol/drugs and not fit to be dealt with until sobriety returned. In relation to the comment regarding a DVPN, this appears to be a comment placed on the incorrect custody record. The offence under investigation was not domestic related and the detention log entry regarding the DVPN was placed on this custody record during the booking in procedure.
Female detainees	1. A Panel member could not find detail identifying a female officer allocated, introducing themselves and for questions relating to pregnancy or menstrual products, the response on the record specified "Not Applicable". Could you verify this and	1. *Female officer allocation is located at the very bottom of the care plan. No female officer was allocated on the first care plan completed, but female officers were allocated on subsequent care plans and changed as per shift changes. The observation by the panel member regarding pregnancy and menstrual products was*

	provide some clarity to this record? 2. Another Panel member also specified that the record they were reviewing was unclear if a female officer had been made available. Can this be checked and validated?	*correct as the custody officer had selected N/A. This is clearly incorrect and should have been answered either "YES" or "NO".* *2. A female officer was not allocated on the first care plan, but it was later updated to show a female officer allocated accordingly. This may have been due to uncertainty as to which officer was going to be allocated.*
Gaps in recording information within the custody record	1. 95% of the records reviewed could not ascertain whether DP was instructed of toilet pixelation, followed by 89% where no detail was found on DP being instructed of the use of the cell call bell and 84% not being provided with information on religious requirements. 2. With regards to Religion, of the 19 records, the Panel discovered that this is either not being recorded or the detail within the record could not be found. 3. Information recorded regarding legal representatives is inconsistent. The Panel noted on five occasions that there was	*1. I am aware that all detainees are being informed of toilet pixelation and use of the cell call bell. This is completed when the DP is escorted to the cell and the toilet pixelation is also written on the cell wall above the toilet via a stencil. There is no template on Niche that covers this process and so this may explain the under recording of this taking place.* *2. Religion is no longer included within the Custody Risk Assessment and this detail is now documented in the "Detainee Name & Info" section of the custody record. This is not a mandatory field that requires completion on Niche and this is something that is*

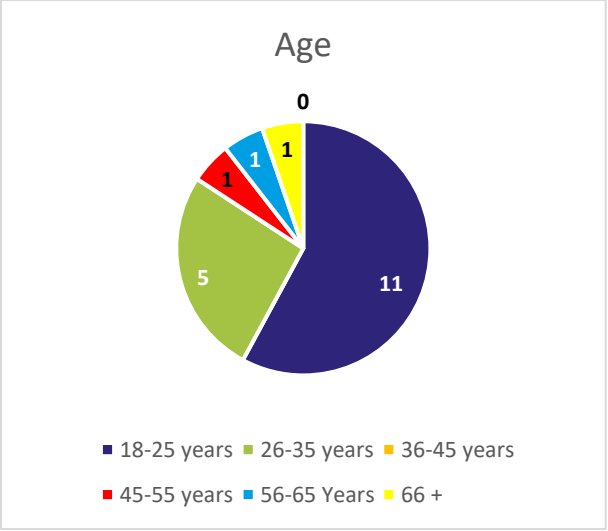
	no record detailing the solicitor contact, type of contact or time of arrival.	*being assessed at present with the other forces within our collaboration.* 3. *All details regarding solicitor, the firm attending, the time they were notified, etc, are all included within the "Rights & Entitlements" section of the custody record. Time of arrival was not initially included in this section; However, following the most recent Niche upgrade, solicitor time of arrival is now included within this section and this should improve the recording of this aspect. I can confirm that all five custody records have solicitor details documented.*
Query regarding the necessity to arrest	One record had a disposal method of NFA with the only necessity to arrest being "*To conduct prompt and effective investigation of the offence."* Can this record be reviewed to ascertain if this vulnerable adult should have been detained?	*I have reviewed the necessity for arrest for this custody record and agree that the arrest was both necessary and proportionate. The DP had been arrested on suspicion of domestic related common assault and controlling and coercive behaviour. The only necessity for arrest listed, as the panel member highlights, was "to conduct a prompt and effective investigation". However, additional necessities could have been recorded given the circumstances such as "to*

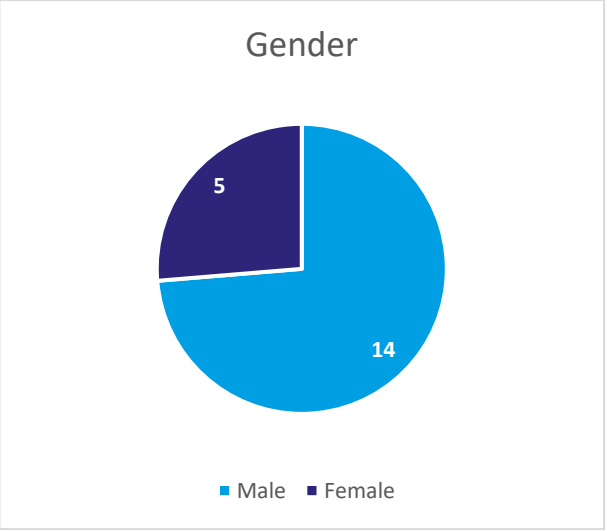
		protect a child or other vulnerable person".
Delay in seeing HCP	Of the 14 DPs that saw a HCP, 5 received a delay. Can you advise whether there was justification for the delay for these 5 records to see a HCP?	*The reasons for the delay in each of the five custody records were:* - *Not deemed to require HCP following initial risk assessment, but then disclosed "brain fog" type symptoms later in detention which required review by HCP for fitness to interview.* - *DP was intoxicated and aggressive on arrival and it was not safe or suitable for HCP to conduct review.* - *There was no delay in DP seeing HCP as first care plan states "DP is currently seeing the HCP".* - *HCP review was requested but the DP fell asleep. HCP was present in custody and advised to cancel the booking and submit a new request when DP awake. There was no urgent need for HCP review.* - *DP required rest period, having arrived during early hours of the morning, and HCP only required to administer medication when it was due later that morning.*

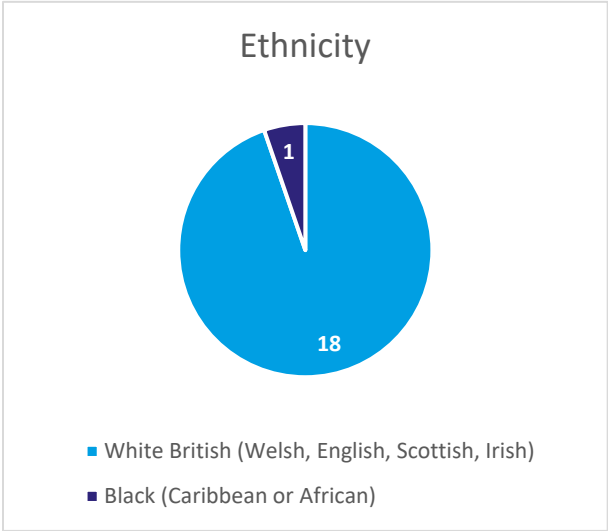
Annex- Custody Record Review Findings

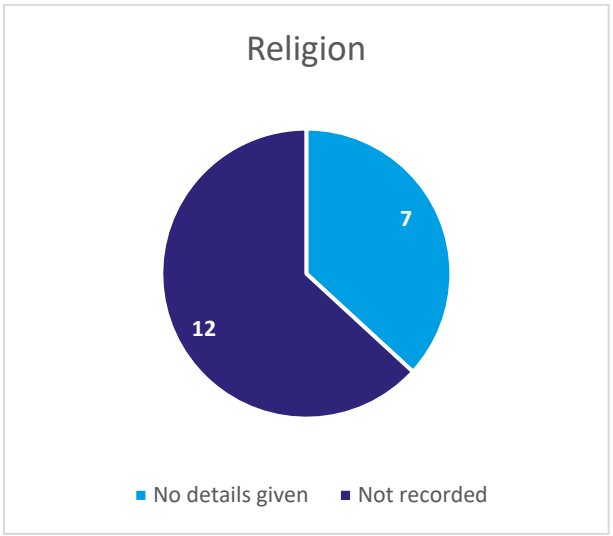
The data below outlines the results of the feedback forms completed by the Panel members which was analysed to identify the positives and areas requiring improvement in each specific area of custody with the focus of vulnerable detainees in custody. This section of the report is supplemental to provide context to the *Summary of Findings* and the *Panel Observations* sections above.

Demographics



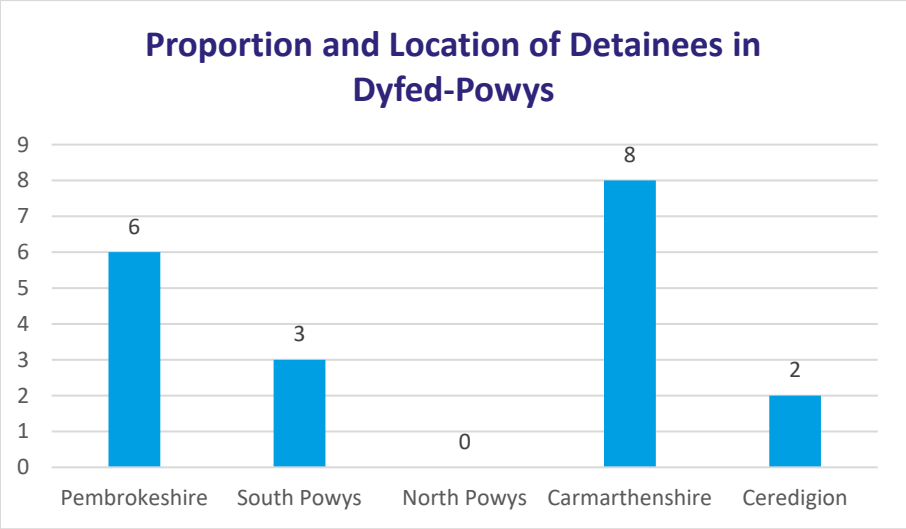






- No children were considered in this dip sample of custody records.

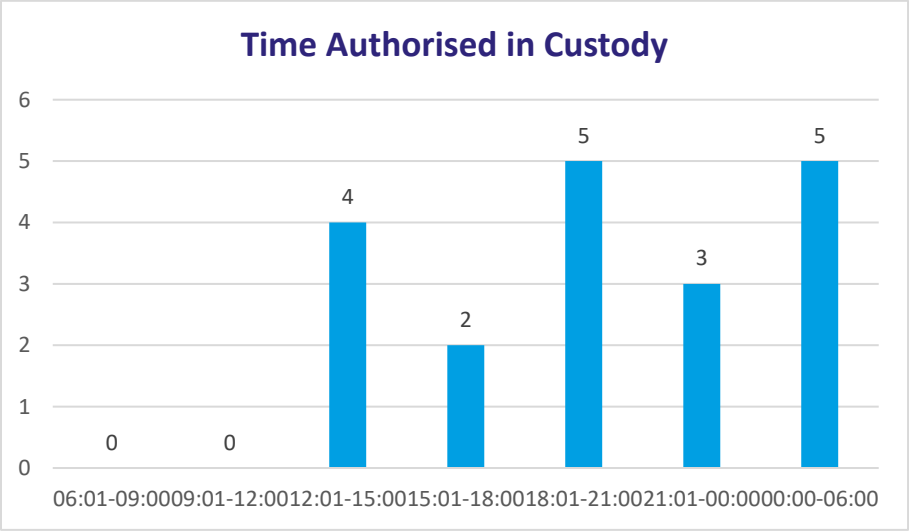
Custody Suites

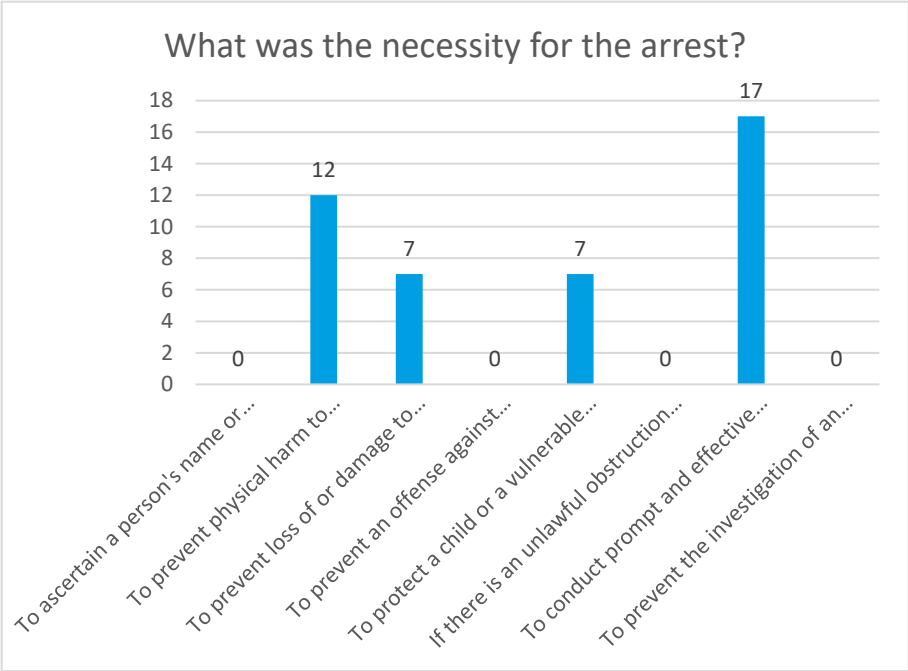


Time Arrived in Custody

Time Lapsed From Arrival to Detention Authorised

- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 27 minutes.
- The highest waiting time was 1 hours and 30 minutes.
- The fastest time for a detained person (DP) to have their detention authorised was 2 minutes.





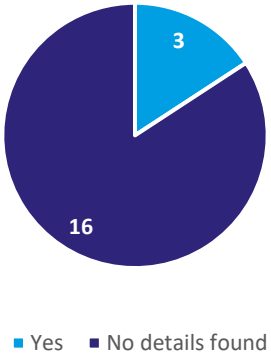
Total Time in Detention

- The average time a detainee was held in custody was 18 hours and 16 minutes.
- The longest time a DP was held in custody was 40 hours and 38 minutes.
- In contrast, the shortest time a DP was held in custody was 2 hours and 9 minutes.

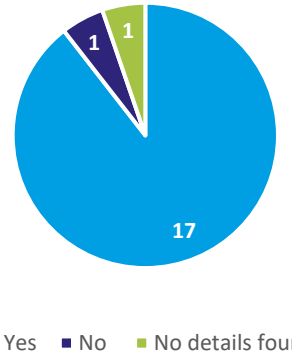
- The Panel were asked to ascertain the necessity for the arrest. An arrest is only lawful if it meets specific legal requirements under S24 of PACE.
- The list of necessities under PACE are:
  - To ascertain a person's name or address
  - To prevent physical harm to themselves or other
  - To prevent loss of or damage to property
  - To prevent an offense against public decency
  - To protect a child or a vulnerable person
  - If there is an unlawful obstruction to the highway
  - To conduct prompt and effective investigation of the offence
  - To prevent the investigation of an offense or the prosecution of the suspect being hindered.
- An officer can choose more than one necessity for making an arrest.
- The most prominent arrest necessity identified was to conduct prompt and effective investigation of the offence.

Provisions in Custody

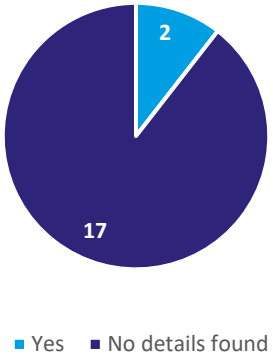
Were religious requirements catered for?



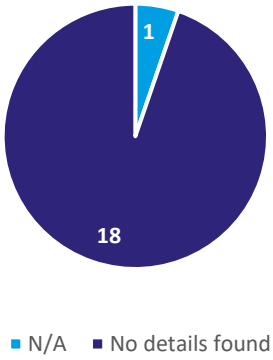
DP was asked about dietary requirements and allergies?



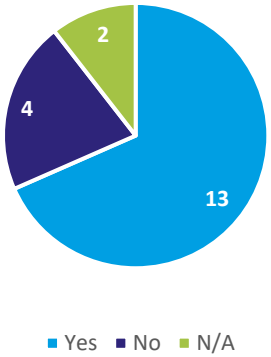
Was the DP instructed in the use of the cell call bell?



Was the DP instructed that the toilet is pixelated?



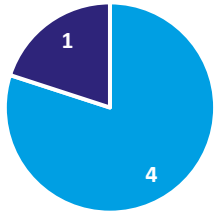
Food an refreshments offered regularly?



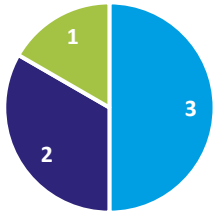
- The Panel specified that there were absences in the recording of religious needs, pixelation of the toilet and cell call button.
- However, in one record, a Panel member noted that a vulnerable adult with autism, anxiety, PTSD and sensory sensitivity was handled in a sensitive manner with all necessary provisions provided to them.

Female Detainees

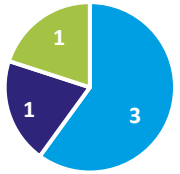
Was a female officer assigned where necessary for a female DP?



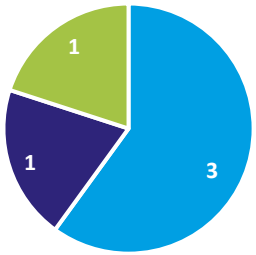
Did a female officer introduce themselves to the DP?



Was the DP asked if they would like to speak with someone from the same sex?

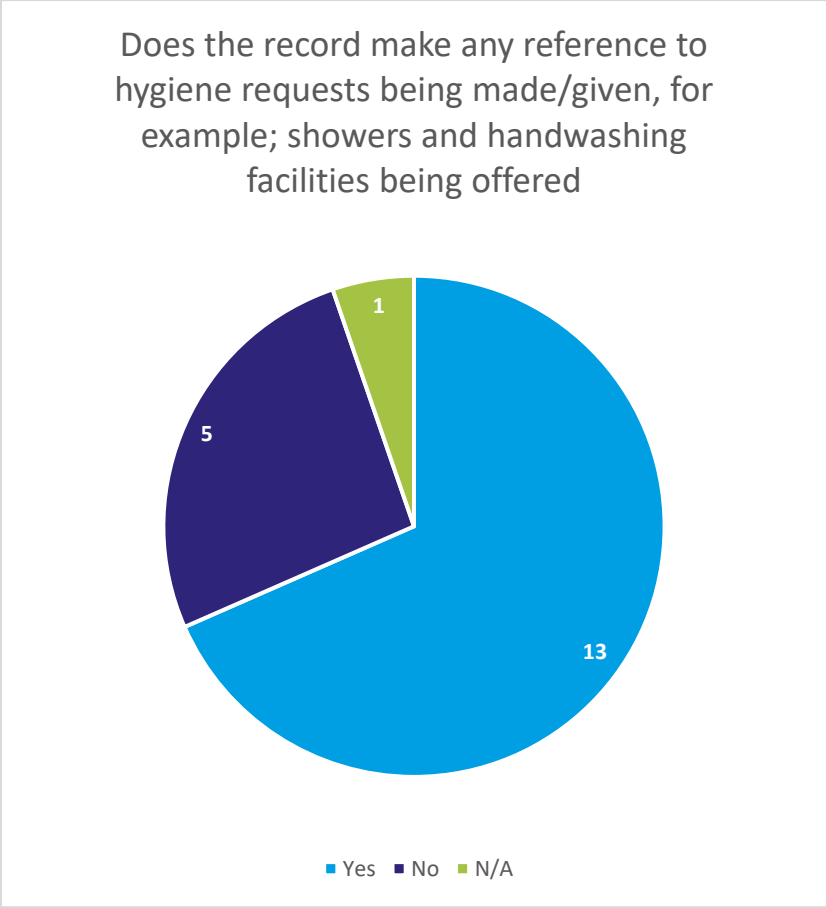


Were menstrual products offered?



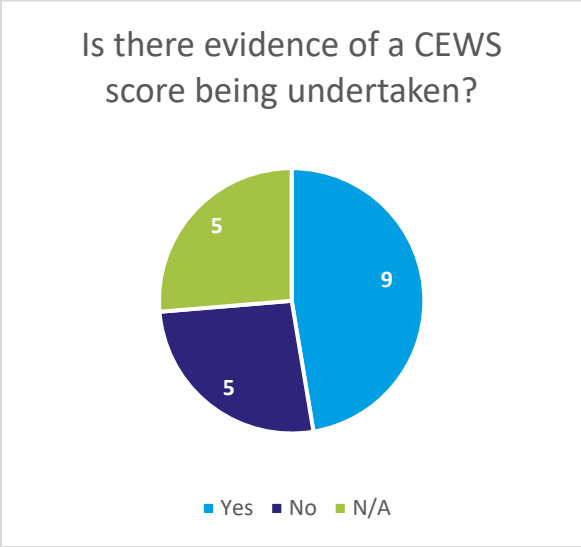
- The Panel specified that the record was unclear on two occasions if a female officer had been available; and in another record, a Panel member specified that the topics surrounding pregnancy and hygiene were recorded as 'Not Applicable'. To see the Inspector's response with regards to this, please go to Panel Observations under *Female Detainees*.

Hygiene


Does the record make any reference to hygiene requests being made/given, for example; showers and handwashing facilities being offered
1
5
13
Yes
No
N/A

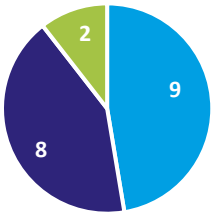
Custody Early Warning Score (CEWS)

Custody Early Warning Score has been added to the normal standardised police risk assessment process to identify detainee morbidity and mortality risk. This is an assessment made by custody staff to assess the detainee's health needs.

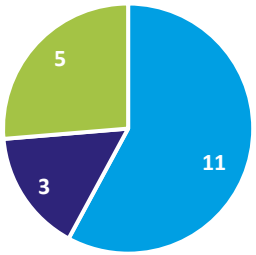


Rights and Entitlements

Was there a delay in receiving R+E (e.g. with AA/interpreter present) of more than 1 hour?



Did the DP see or speak to a Solicitor?



- All DPs were given their rights either at booking in stage or at a later stage during their detention.

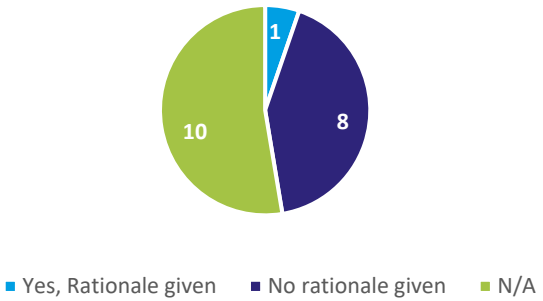
How long, after detention authorised, did the DP request a solicitor?

- The average time for a detainee took to request a solicitor was 1 hour 56 minutes.
- In 8 of the 19 of the records, the DP made the request for a solicitor within one hour and 2 records declined a solicitor.
- The longest period for a DP to request a solicitor was 6 hours and 30 minutes.

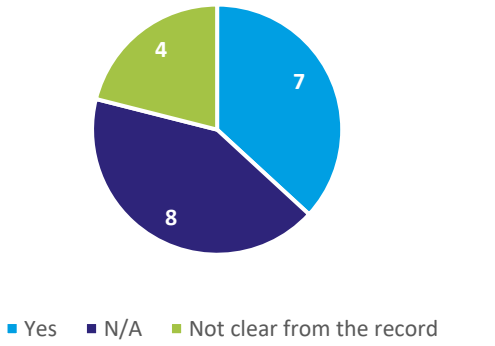
The length of time taken for police to contact a solicitor

- The average time taken was 2 hours and 33 minutes for police to contact an on-duty solicitor.
- The longest period of time was 8 hours.
- The shortest was 2 minutes.

If there was a lengthy delay in seeing a solicitor, was there any rationale available?

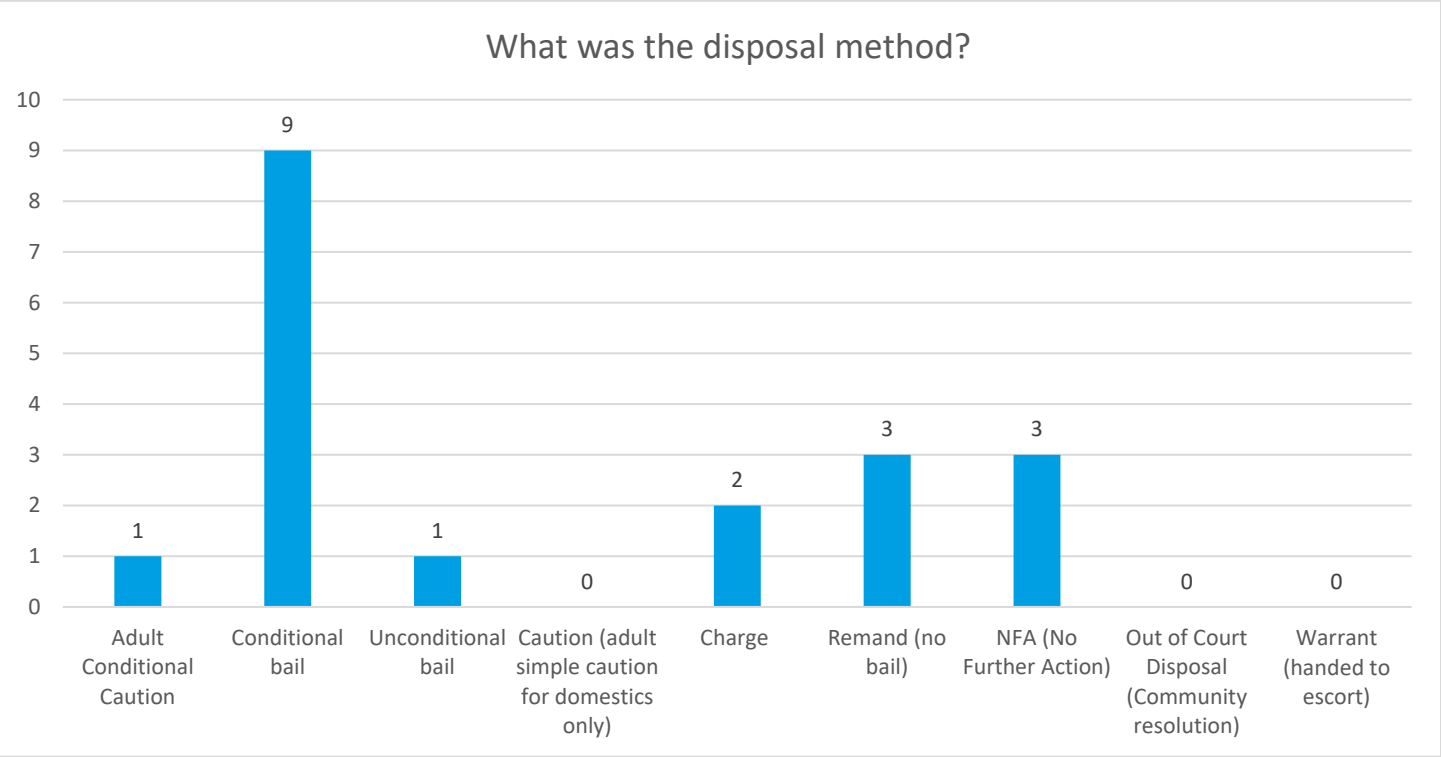


Was solicitor advice given in person?



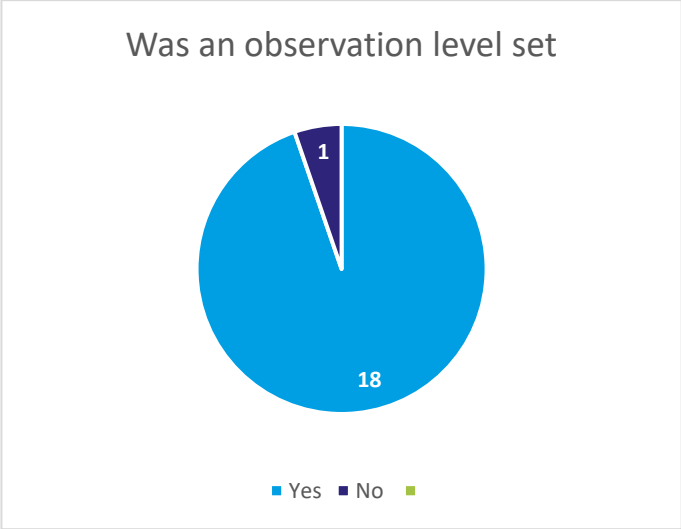
The length of time taken for solicitor to arrive from the point of being contacted

- The average time it took for a solicitor to arrive after being requested was 7 hours and 19 minutes.
- The Panel noted on five occasions that there was either no record or it was difficult to ascertain details surrounding the contact of a solicitor contact.
- The Panel made the following observations on the difficulties in assessing solicitor involvement within the custody record:
  1) *"It appears that solicitors were contacted, but it is unclear as to whether or not any solicitor attended the interview."*
  2) *"The record is confusing in that although the DP requested a solicitor at 13.54, no contact was made until 22.37 when the AA was present".*
  3) *"It is not possible to ascertain whether the conversation between the DP and solicitor was in person or over the phone."*



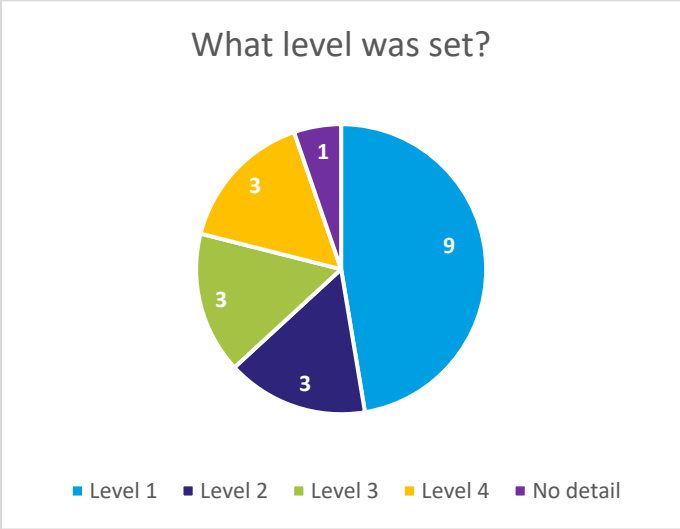
- The Panel were asked to note the disposal method to assess whether
- 47% of disposal methods was for conditional bail which is the process that allows officers to attach conditions to bail which may support victims and/or witnesses, preservice evidence and mitigate further crime.
- Of the three records with the disposal method being NFA, the arrest necessity specified for each of them was *To conduct prompt and effective investigation of the offence*. For two other records, one was highlighted to *Protect a child or other vulnerable adult* and the other was to *Prevent person causing loss or damage to property.*

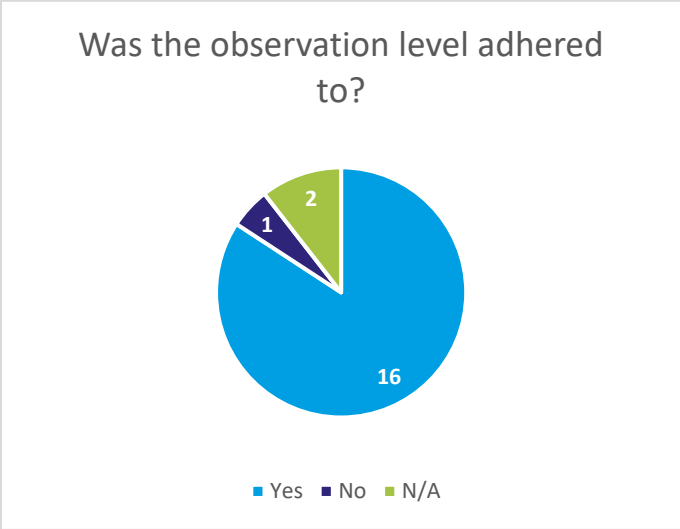
Observation Level



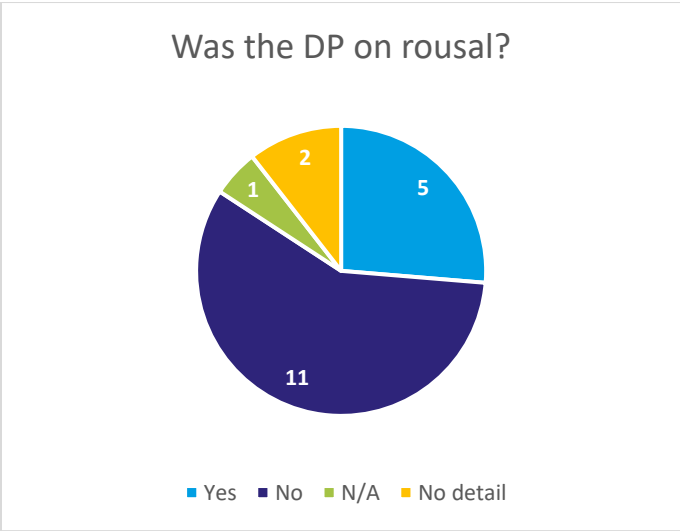
- The risk level is judged on 4 levels.
- Level 1 General (at least once every hour)
- Level 2 Intermittent (every 30 minutes)
- Level 3 Constant (constant observation CCTV and accessible at all times)
- Level 4 Close Proximity (physically supervised in close proximity).

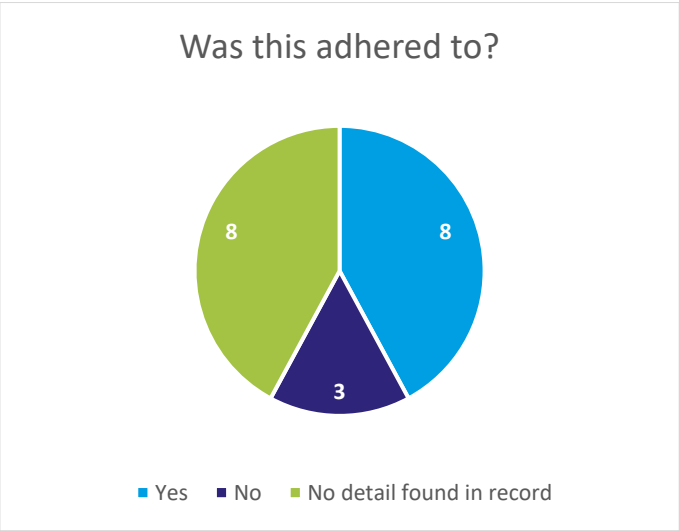
- The Panel recorded 95% confirmation that DPs risks were taken into account with only one record where the Panel member could not find the detail.





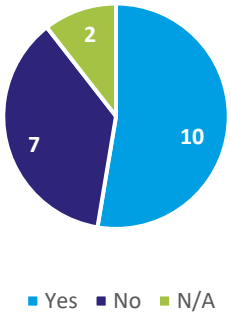
- One Panel member noted that the observational level 2 was not adhered to.
- Another Panel member put not applicable as they could not see detail on any observational level to begin with.
- The Panel made the following comments in relation to the observational levels:
  1) Observation levels changed from Level 1 to 2 to 4 and back to 1 on HCP advice.
  2) DP who had head injuries and markers for mental health issues and previous suicidal ideation was initially placed on L1 until approx. an hour later when this was revised to Level 4 with no clear rationale provided.
  3) As a DP was only held for 2 hours and 9 minutes there was no detail for rousal.



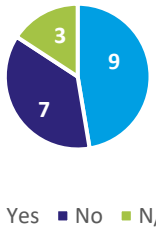


Support Services

Was the DP given access to/offered/referred to any support services?



Is there any evidence of contact with support services/Mental Health Team/or reasons provided for no contact?

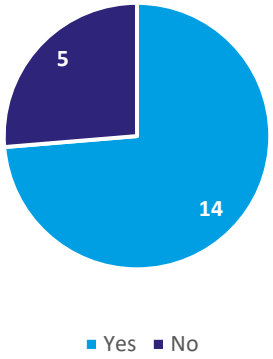


- 53% of DPs were offered support services in comparison to 37% who were not and 10% that this was not applicable.

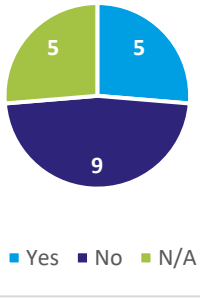
- Panel members stressed the following support services to support DPs:
  1) MH services
  2) Kaleidoscope
  3) General Practitioner
  4) HCP

Healthcare Professional (HCP)

Did the DP see a healthcare professional?



Was there a delay in healthcare professionals attending and DP receiving a health assessment?

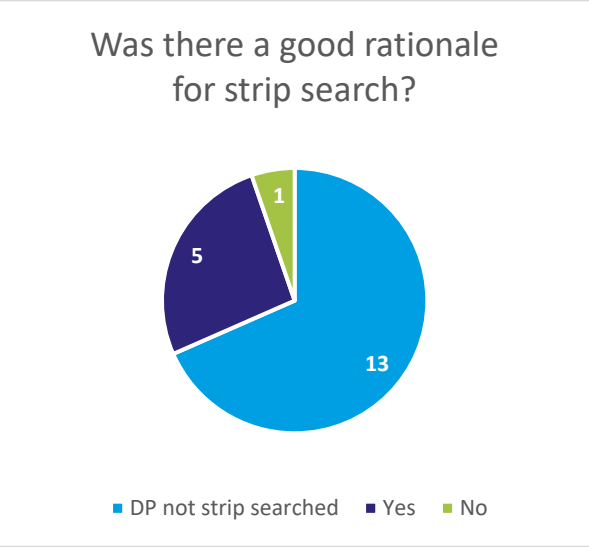


- The Panel noted the following observations in relation to HCP provision:
  1) Custody professional and caring referred to HCP appropriately.
  2) Custody staff identified that the DP had a history with MH and learning difficulties.
  3) Good practice that the record shows understanding that previously an AA was deemed necessary so appears to have given extra regard for the requirement on this occasion.
  4) Mental health concerns have been acknowledged whilst the DP was in custody and HCP assessments sought. AA was contacted and attended in time for interview.

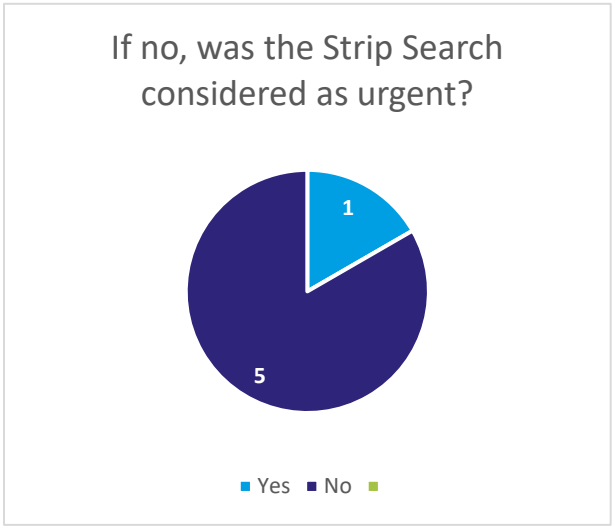
Special Risk Clothing (SRC)/Anti-Rip Suites

- Of the 19 custody records reviewed, no detainee was provided with SRC and no clothing was removed by force.

Strip Search



- One Panel noted that there was not a good rationale for a strip search to have been conducted. The rationale provided was that the DP had been arrested on suspicion of supply of drugs. DP had already been to hospital and scanned in case he had swallowed any item, and bowel movements were monitored via the glass toilet; therefore, uncertain why a strip search was necessary.
- There was no Appropriate Adult (AA) present for any of the strip searches conducted.



The Panel noted the following reasons why these detainees were considered vulnerable:

- DP suffers early onset dementia.
- MH issues including depression, anxiety, ADHD.
- Inability to read or write.
- DP having the mental capacity of a 6 year old.
- DP with learning difficulties.
- History of self-harm.

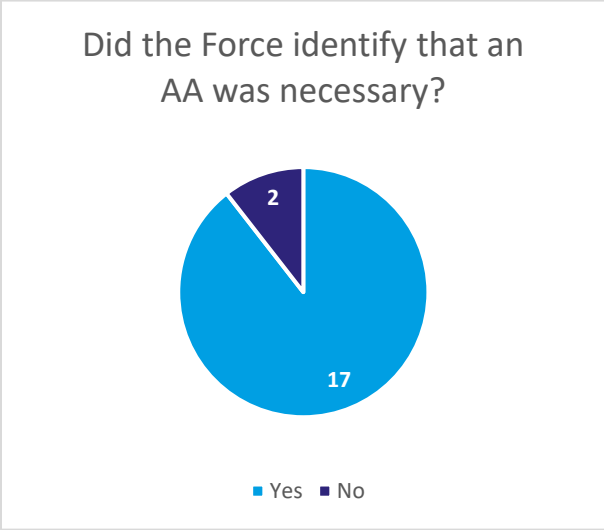
There were records whereby the Panel could not determine why the DP was considered vulnerable.

Of those records that identified vulnerability:

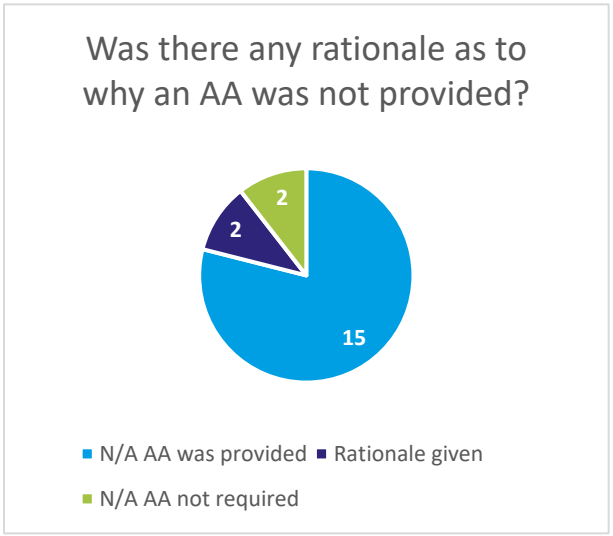
- MH issues 31%
- Neurodiversity 15%
- Unable to read or write 21%
- Learning Difficulties 21%

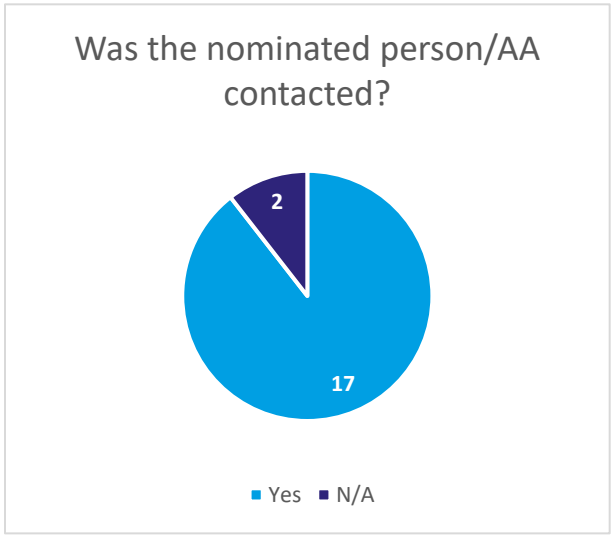
Of the remaining 12%, this included risk of self harm and onset of dementia and two records specifying that the DP was not vulnerable.

Mental Health (MH), Appropriate Adults (AA) & other Vulnerabilities



- The average time for a detention officer to make contact with AA was 7 hour and 30 minutes, and the average time the DP first made contact with an AA was 8 hour and 10 minutes.
- The longest period was 19 hours and in contrast the shortest was 4 minutes.
- The Panel noted that on one occasion an AA was not provided due to the DP appearing to have capacity; however, required an AA on a previous occasion in custody.
- The Panel had the following observations on AA:
- There was no explanation provided for why an AA was contacted 11 hrs into custody to accompany to interview.
- There were two records where information was absent in the record for the delay in the AA arriving.





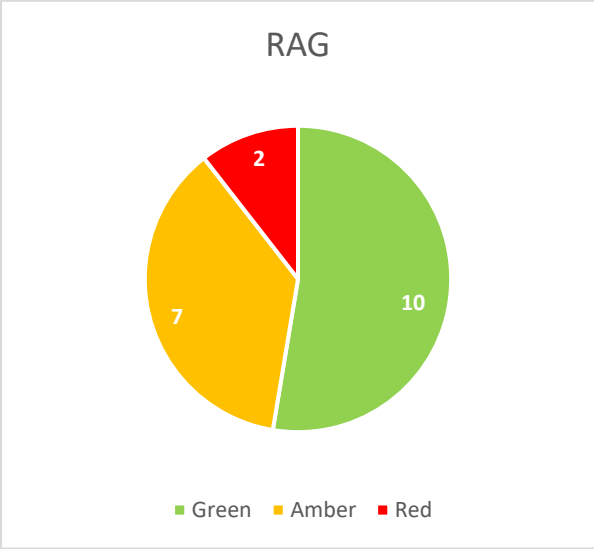
Children in Custody

No children DPs were selected as part of the dip sample of vulnerable detainees.

Red Amber Green (RAG)

At the end of each custody record reviewed, the Panel were asked to review the below criteria and assess their overall grading of the custody record using the RAG rating:

Examples of Reason for Rating	Follow Up Action
Full rationale provided for use of force, strip search or and for any delays from external agencies supporting detainees which are both justifiable and proportionate.	**No further action required at this point.**
All Rights & Entitlements have been provided to the detainee.	
Clear de-escalation, distraction items etc. used to mitigate risk of detainee DSH.	
Little or unclear justification for the use of the Anti-Harm Suit, use of force or strip search.	**Advice/further training given to custody staff.**
Insufficient information to determine any delays in the detainee receiving their rights for legal representation or an appropriate adult.	
Inconsistent recording of Rights & Entitlements.	
No rationale or justification is not proportionate.	**Further exploration required in relation to lack of rationale. Cases to be raised with custody inspector.**
Decisions made in the absence of risk information and with no other rationale.	
Significant delays in detainees seeing HCP, legal services or an appropriate adult.	
No apparent consideration for detainee's vulnerabilities.	



The rationale assigned to each colour grading were of individual Panel member's assessment/judgement of the custody record they were assigned to. Below are some of the rationale the Panel provided for their grading:

Green	Amber	Red
"All very good - the only omission is mention on the record of the DP being informed of the call bell or pixelated toilet."	*"Delays over time in contacting the AA, no reason given."*	*"The DP was placed in 'Cell C18 Drugs Recovery Toilet' which is suggestive of an additional level of vulnerability but there is no evidence in the risk assessment. Likewise, the record indicates no mental health needs and an AA is recorded as not required. Yet 11 hrs into custody an AA is contacted and attends interview - without any explanation on the record for why"*
"DP treated well and in accordance with Code C"	*"Positives: repeated contact with HCP to ensure this detainee's physical wellbeing. Negative: this detainee was arrested at 8:16 - taken to hospital for a scan, then to H'west custody suite, where detention was authorised at 13:57 on 11/01/25. It took until the 6 hour review by the Inspector to offer this detainee food and*	*"There is a lack of information on the record to determine rationale for strip search, why AA identified as required but not contacted until much later, no record of solicitor being contacted and what appears to be a record relating to another case on the file"*

	drink. Thereafter he was offered refreshments on a regular basis, declining on occasions; he accepted the offer at 00:14 on 12/01/25."	
"Multiple offences committed by a mental health sufferer who should more properly NOT have been the province of the Police Service rather than appropriate Mental Health authorities."	*"Only real concern is the initial allocation of Level 1 observations (probably to low) - and the sudden change to Level 4 without any clear rationale"*	
"Detained minimum time then transferred too crisis team"	*"DP did not appear to have been offered sufficient and appropriate food or drink. Only 1 pot noodle and water given in over 17 hours in custody. Also conflicting information regarding the decision as to whether the DP required an AA."*	