



Mae'r ddogfen hon ar gael yn Gymraeg yn ogystal â Saesneg.

This document is available in Welsh as well as English.



Comisiynydd Heddlu a Throseddu
Dyfed-Powys
Police and Crime Commissioner



Heddlu Police
**DYFED
POWYS**

June 25th 2026

Police and Crime Commissioner for Dyfed-Powys
Authored by: Tom Walters

Custody Independent Scrutiny Panel: Use of Force in Custody

Contents

Introduction 2

Summary of Findings 4

Panel Observations 6

Annex- Custody Record Review Findings.....27

 Demographics..... 27

 Custody Suites..... 28

 Time Arrived in Custody 28

 Provisions in Custody 31

 Female Detainees 33

 Hygiene 34

 Rights and Entitlements 35

 Observation Level..... 38

 Support Services 39

 Healthcare Professional (HCP) 40

 Use of Force..... 41

 Strip Search..... 43

 Children in Custody 46

 Red Amber Green (RAG)..... 47

Introduction

The origins, purpose and rationale of the Custody Independent Scrutiny Panel (CISP) can be found within the Panel's Terms of Reference, available on the [Office of the Police and Crime Commissioner website](#). The CISP provides independent scrutiny of custody detention records and practices, offering assurance to the public that detainees are treated fairly, lawfully and with dignity whilst in police custody.

As part of the Panel's cyclical approach to scrutiny, members periodically revisit previously reviewed themes to assess whether identified learning has been embedded and whether improvements have been sustained. On 25 June 2026, the CISP focussed on the use of force within custody settings. This topic was selected due to its significant importance in ensuring that the rights, welfare and safety of detainees are protected whilst enabling custody staff to effectively manage risk and maintain safety within custody environments.

The use of force in custody sits at the intersection of human rights, safeguarding, accountability and public confidence in policing. Any force used against a detainee must be lawful, necessary, reasonable and proportionate to the circumstances presented. Force should only be used as a last resort after other options, including communication and de-escalation techniques, have been considered or attempted. Equally important is the requirement that any use of force is appropriately recorded, justified and subject to effective oversight.

In preparation for this scrutiny activity, Panel members were reminded of findings from previous reviews of use of force in custody. Historically, the Panel found that force was generally used lawfully and proportionately, with custody staff demonstrating good decision-making and a clear focus on safeguarding both detainees and staff. The Panel also identified examples of effective de-escalation, appropriate post-incident welfare monitoring and a positive custody culture centred upon communication and care.

Whilst previous scrutiny activity highlighted a number of positive practices, recurring areas for improvement were also identified. These principally related to the quality and consistency of recording, including insufficient detail within custody records regarding the type of force used, the rationale for its application, the duration of incidents and de-escalation attempts made prior to force being used. Previous reviews also found that vulnerabilities, including mental health considerations and other risk factors, were not always clearly linked to decision-making within the record itself. As a result, the Panel sought to examine whether improvements had been made in these areas and whether learning identified through earlier scrutiny had been embedded within custody practice. For further details of last year's report, you can access the record [here](#).

For this review, Panel members were provided with a series of custody records where force had been used during detention. Members were asked to consider whether the force applied appeared necessary, proportionate and appropriately justified, whether detainee vulnerabilities had been adequately considered, and whether sufficient information had been recorded to enable meaningful scrutiny. Members were also reminded that use of force forms completed by officers are retained within Niche (Police database) and do not form part of the custody record itself. Therefore, the Panel's assessment focussed on:

- 1) Whether the custody record clearly documented that force had been used,
- 2) What type of force was applied,
- 3) The reasons it was necessary,
- 4) The officers involved and the outcome of the incident.

The findings contained within this report represent the observations of CISP members following their review of the selected custody records. The report highlights examples of positive practice, identifies opportunities for improvement and seeks to support continued learning and development within Dyfed-Powys Police Custody Services:

QR code:



Link: [Custody Independent Scrutiny Panel \(25/06/2026\) UoF in Custody – Fill in form](#)

Summary of Findings

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

Positives:

Use of Force

- The Panel found evidence that force was generally applied in response to identifiable risks including violence, aggression, self-harm and significant intoxication.
- The Force have demonstrated robust internal oversight arrangements, including the auditing of use of force incidents and identification of learning opportunities.

Risk Management

- Observation levels were appropriately set, regularly reviewed and adhered to throughout detention.
- Examples of de-escalation, distraction techniques and multi-agency engagement were evident within several records.

Safeguarding

- Good examples of safeguarding, welfare monitoring and vulnerability management were identified.
- Custody staff demonstrated consideration of detainees' mental health, medical needs and safeguarding requirements.
- Support services and Healthcare Professional referrals were regularly considered where appropriate.

Female Detainees

- Female detainees were consistently allocated female officers and offered relevant gender-specific provisions.

Areas for improvement:

Recording of Use of Force

- Recording of use of force within custody records should be clearer and more consistent, including the type of force used, rationale, timing and outcomes.
- Greater consistency is required between custody records and Inspector reviews to ensure an accurate and reliable audit trail.
- Where force is used, sufficient detail should be recorded to enable effective independent scrutiny without reliance on supplementary systems.

Strip Search

- Strip search records would benefit from more detailed rationale explaining necessity and proportionality.
- Records should consistently document when detainees are informed that CCTV has been obscured, disabled, or otherwise managed during strip searches.

Recording of Observation Level Entries

- Observation level entries should be recorded in a manner that avoids ambiguity and clearly distinguishes between observation levels and care plan types.

Appropriate Adults

- Decision-making relating to Appropriate Adults should be clearly documented where initial assessments change during detention.

Delays in External Services Arriving

- Additional contextual information regarding delays involving legal representatives, Appropriate Adults and other external services would further strengthen transparency.

Panel Observations

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

Theme	Observation	Force Response
Observation Level	One CISP member noted that the recording of observation and care plan levels was not always clear or consistent within their custody record. In several instances, entries appeared to reference different observation levels simultaneously or described observation practices that did not obviously correspond with the level recorded. This created ambiguity regarding the detainee's actual observation status and made it difficult to determine whether the level of monitoring was accurately documented and consistently applied. Given that clear and consistent recording of observation levels is essential to ensure an accurate audit trail and effective risk management could you provide some clarity on the entries referenced in this instance. For the same record, the CISP member noted that the custody record does not clearly establish whether force was used during detention or whether handcuffs were applied solely at arrest and subsequently removed in custody. Furthermore, no time has been	<i>Custody record reviewed and I understand where the confusion has arisen for the reviewing panel member. Within the care plan endorsement by the initial custody officer the care plan "type" was listed as "L4". The "type" section is present to allow custody officers to indicate the reason for the care plan such as handover, following interview, FTR, etc. On this occasion the custody officer, as stated, has endorsed that section with the initial observation level that was initially set which was L4. Unfortunately, the same custody then completed a further 5 care plans before handover and the "type" was not changed, even though the observation levels had clearly been altered. The "type" as then changed following handover where the incoming custody officer endorsed the "type" as "handover".</i> <i>However, having reviewed the custody record in full, Custody Services can provide reassurance that observation levels were adhered to throughout.</i>

	recorded for the removal of the handcuffs, with the field at 01:22 BST stating "If handcuffs, time handcuffs removed:" left blank. This limits the audit trail and makes it difficult to determine the extent and duration of any use of force.	<i>In relation to the panel member observation regarding use of force; the risk assessment clearly highlights this. The question "Was force used whilst in custody?" is answered using drop down option "handcuffs". The risk assessment records that handcuffs and open hand techniques used before detention and handcuffs in custody.</i> <i>The question "If handcuffs, time handcuffs removed:" is left blank because handcuffs was not actually selected from the drop-down menu, with only "open hand techniques" and "other" being selected. If "handcuffs" is not selected from the drop-down menu then the above box does not appear on Niche for a time to be inputted. Handcuffs should have been selected given that the details provided on the risk assessment state "DP WAS HANDCUFFED ON ARREST AND HANDS ON TECHNIQUES USED".</i> <i>Whilst the force is satisfied that this DP was suitably cared for, and observation levels adhered to, throughout detention, there is learning to be taken. Firstly, custody officers must ensure that the care plan "type" is amended to avoid confusion between that and the observation level set. Secondly, to</i>
--	--	---

		<i>ensure that the correct use of force type/s are selected from the drop-down menu to ensure that additional fields appear as required.</i> <i>Feedback will be provided to the custody officer involved.</i>
Use of Force	One CISP member noted that the custody record contains an entry stating that a police sergeant and constable entered the cell and removed the detainee's bottoms. However, the record does not specify whether any force was used during this intervention, nor does it provide sufficient detail regarding how the removal was carried out. In contrast, the Inspector's review records specified that no force was used in custody. This apparent lack of detail makes it difficult to establish a clear audit trail of the circumstances surrounding the incident. <i>Question to the Force: Can the Force clarify whether any force was used during this intervention and, if not, whether the custody record contains sufficient detail to explain the actions taken and reconcile them with the Inspector's review stating that no force was used in custody?</i>	<i>Custody record reviewed and Custody Services can confirm that force was used in custody. The answer to the question "Was force used whilst in custody?" is answered with "other – see log entry" from the drop-down menu. The first care plan recorded documents that the DP was heavily intoxicated, obstructive, and attempted to tie bottoms around his neck when placed in the cell. These were removed using reasonable force by the custody officer and DEO who entered the cell.</i> <i>However, it is agreed that a little more information regarding how the item was removed would be beneficial for audit purposes. Feedback will be provided to the custody officer.</i> <i>The PACE review completed by the Inspector does state that NO force has been used in custody, which is incorrect. This is an oversight by the inspector in question and feedback will be provided.</i>

	With the entry included above, there were 7 additional records where the CISP found: - It was unclear whether force had been used within the custody suite and, where force may have been used, the specific type of force applied could not be readily determined from the record. - In two of these cases, the custody entries appeared inconsistent with Inspector reviews, which stated that no force had been used on the detainee. - While some rationale for actions taken was recorded, the member considered that the recording lacked sufficient clarity and transparency to provide a clear audit trail of events and decision-making. Question to the Force: <i>Can the Force provide assurance that the recording of use of force incidents within custody is sufficiently clear, detailed and consistent to enable effective scrutiny, particularly where custody record entries appear to differ from</i>	<i>In relation to the first two custody records noted where it was difficult to ascertain if force used in custody or not:</i> - <i>the first custody record has already been addressed by the force due to poor recording – there were several, separate instances of use of force in custody but none were reflected on the custody record. Feedback has already been provided to all custody officers involved, and ALL officers involved have submitted use of force forms as required.</i> - <i>The second custody record does provide sufficient information regarding use of force in custody and appears to be an oversight by the reviewing panel member. The risk assessment evidences "open hand techniques" as use of force in custody due to the DP's aggressive demeanour. DP was escorted straight to the cell, cell procedure conducted.</i> <i>In relation to the two custody records where the inspector reviews are inconsistent with the record itself:</i>
--	--	--

	<i>Inspector reviews stating that no force was used? Additionally, what measures are in place to ensure that the rationale for interventions and any use of force are transparently documented?</i> Four CISP members reported difficulty locating a clear custody entry recording the use of force despite the record having been selected as part of a use of force scrutiny exercise. This limited members' ability to determine what force had been used, when it occurred, and the rationale for its application. <i>Question to the Force: Can the Force provide assurance that all use of force incidents occurring within custody are appropriately recorded within custody records and explain why use of force entries could not be readily identified in these cases?</i>	- <i>Both records have been checked, the custody record documents use of force in custody, yet the inspectors on both occasions state "no" use of force within their PACE reviews. This is an oversight by the inspectors and feedback will be provided.</i> <i>In relation to the custody record which the panel member observed to be lacking clarity:</i> - <i>Custody record has been reviewed, and Custody Services believe that sufficient information has been recorded to outline what force has been used and the rationale behind that decision. The care plan records that the DP is aggressive, abusive, and was escorted straight to the cell. The DP then wrapped clothing around his neck that required force to remove. As explained to panel members, DPP does not expect entries to be overly thorough within the custody records as use of force is recorded via "use of</i>
--	---	--

		<i>force" forms that are completed by all officers involved. The custody record is supplementary to those forms.</i> <i>In answer to the question regarding assurance that recording of use of force is sufficiently detailed and any rationale is transparently documented; the force already has thorough quality assurance measures in place and use of force in custody is a key area that comes under monthly scrutiny. The force currently audits 100% of use of force in custody which includes a full review of the custody record, the download and review of CCTV for that incident, and any learning is identified and addressed during monthly custody performance meetings.</i>
Strip Search	A CISP member reviewing the record noted that they were unable to clearly identify from the custody record the rationale for conducting a strip search of the detainee. Whilst the strip search was recorded, the grounds and decision-making underpinning the search were not sufficiently detailed to enable the member to understand why the search was considered	<i>Custody record reviewed. The strip search has been recorded correctly within the "searches" section of the custody record and there is an additional "search" detention log entry which provides additional information. The rationale provided centres around the detainee's demeanour, his active comments regarding self-harm/suicide, and warning markers for suicidal and drugs. Whilst the</i>

	necessary and proportionate in the circumstances. Question to the Force: <i>Can the Force clarify the rationale for conducting strip search on this detainee was?</i> In all four records, it was unknown or unclear whether the DP had been advised that the CCTV was either obscured or turned off for the purposes of the search. Question to the Force: <i>Can the Force provide assurance that this information is routinely communicated and explain how compliance is recorded?</i>	<i>strip search is considered to be necessary to prevent risk/harm to the detainee or other persons, Custody Services agrees with the observation that the rationale lacks sufficient detail to fully understand the rationale. Additional information could have been included such as information from the arresting/conveying officers, context regarding the incidents that resulted in the warning markers being placed on the detainee, etc.</i> <i>Feedback will be provided to the custody officer involved. For assurance, Custody Services has recently increased the sample size of strip searches to ensure additional scrutiny in this area.</i> <i>In relation to the four records identified as being unclear whether DP had been advised that CCTV was obscured or turned off:</i> - <i>The first record was not a strip search, it was a Davies v Merseyside exchange of clothing, and so CCTV requirement does not apply.</i> - <i>The second record was a strip search, the CCTV aspect is included within the rationale but does not</i>
--	--	--

		<i>specify that the DP has been advised.</i> - <i>The third was a strip search, the rationale includes CCTV being switched off to preserve the dignity of the DP but does not specify that the DP has been advised.</i> - <i>The fourth record was conducted in Dafen, which has a dedicated strip search room with no CCTV, but the custody officer opted to conduct the search in a cell. The custody officer provides rationale for this decision based on the DP's level of aggression, making active threats towards officers, and so the custody officer deemed the search room not to be suitable. CCTV was required to ensure safety of all persons. College of Policing accept that CCTV can be utilised if suitable rationale is provided.</i> <i>Detainees being advised of CCTV being obscured or turned off should be recorded as part of rationale or within a separate detention log entry. Whilst all rationale includes information regarding CCTV being obscured or turned off, the fact that the DP has been informed is not</i>
--	--	--

		<i>always included. This is an area which the force will look to closely monitor and address.</i> <i>For reassurance of panel members, Custody Services have recently identified designated rooms/cells within each custody suite that will be used as designated search rooms. Each of these rooms will either have no CCTV, or controllable CCTV system allowing CCTV to be turned off completely for that room for the duration of the search. This will ensure that no strip searches are recorded to preserve the dignity of the detainee. This falls in line with recent IOPC recommendations.</i>
Appropriate Adult	One CISP member noted concerns regarding the involvement of an Appropriate Adult (AA). The custody record indicates that the Force initially identified a requirement for an AA; however, during handover, the custody sergeant was informed that an AA was not required for the custody process. The detainee was subsequently charged and sent directly to court without the attendance of an AA. The member was unable to determine from the record how the detainee's understanding of the process was assessed or what rationale underpinned the decision that an AA	<i>Custody record has been reviewed but first I will address the requirement for an Appropriate Adult in general. The requirement for an AA is based on an assessment of the detainee's capacity to understand what is happening, custody processes, etc. The fact that a detainee is diagnosed with an ongoing mental health concern, such as depression, does not automatically mean that a detainee lacks capacity. In addition, I note that the panel member documents physical health concerns, but there is no correlation between physical health concerns and a detainee's capacity and so very</i>

	was no longer necessary. The member further noted that the detainee was recorded as having bipolar disorder, depression, and several physical health conditions, including arthritis. Given these recorded vulnerabilities, the rationale and decision-making relating to AA provision were not sufficiently clear within the custody record. Question to the Force: <i>Can the Force clarify the rationale for determining that an Appropriate Adult was no longer required after initially being identified as necessary? Additionally, what assurances can be provided that the detainee's understanding of the custody and charging processes was appropriately assessed and supported, particularly in light of the vulnerabilities recorded within the custody record?</i>	<i>rarely impact upon the requirement for an AA.</i> <i>Focusing on the detainee within this custody record, the risk assessment documents diagnosis for bi-polar disorder and depression, and the initial custody officer suggests an AA should be considered. However, the detainee was heavily intoxicated, irate, and uncooperative on arrival. Therefore, rights and entitlements could not be provided, and AA request could not be made until detainee was sober so that rights could be given. These would need to be completed following sufficient rest period and handover to morning custody officer. HCP review was also not possible based on detainee's intoxication and demeanour. The offence that the detainee was arrested for was Breach of Domestic Violence Protection Order, this does not require interview or processing, and so the detainee was not charged. Breach of DVPO requires arrest and conveyance to next available court. AA would have only been required for purposes of rights and entitlements. Following handover to morning custody officer, a "handover" detention log entry has been completed which documents that the custody officer has spoken to the DP at the desk and rights and</i>
--	--	--

		<i>entitlements have been provided now calm. The DP was also reviewed by HCP and deemed fit for transfer, did not lack capacity, and an AA is not required for custody processes. Prior to DP being conveyed to court, a solicitor had been arranged and would attend court to provide legal representation.</i> <i>Based on the above, Custody Services agrees that the DP did not require an AA. The custody record does evidence that an AA was considered but it was difficult for the initial custody officer to adequately assess the requirement for an AA due to the DP's level of intoxication and irate demeanour. However, once sober the detainee has been reviewed by the morning custody officer and HCP and both agree that the DP did not lack capacity and no AA required for custody processes which only included understanding of rights and entitlements and that DP was being conveyed to court for breaching a DVPO.</i> <i>However, I understand the concern raised by the panel member given the vulnerabilities identified. As previously stated, diagnosis of one or multiple health concerns does not automatically mean an AA is required.</i>
--	--	--

		<i>Requirement for an AA is based on a detainee's capacity to understand, not what they have been diagnosed with alone. The requirement for an AA is an informed decision made by the custody officer with the medical guidance of custody HCP's.</i>
Legal Services	Two CISP member noted that the custody record provided no explanation for the period between the detainee's request for legal advice and the solicitor's arrival. Whilst the relevant times were recorded, there was no accompanying rationale to explain any delay or to demonstrate what actions were taken to facilitate timely access to legal representation. As a result, the member was unable to fully understand the circumstances surrounding the wait for legal advice from the information contained within the record. Question to the Force: <i>Can the Force clarify whether there was a delay between the request for a solicitor and the solicitor's attendance, and if so, why this was not explained within the custody record? Additionally, what measures are in place to ensure that any significant delays and the reasons for them are clearly documented to support transparency and effective scrutiny?</i>	<i>First custody record reviewed and Custody Services do not agree with the panel member observation that there was a delay between the detainee's request for legal advice and the solicitor's arrival. Solicitor was requested at 1520hrs, solicitor attended custody promptly, DP was interviewed and released from custody 2 hours 40 minutes later. This is not considered a delay between request and arrival. However, I am unclear whether the panel member may be referring to the detainee's arrival time and the request or attendance of legal representation in this case? The reason I suspect this observation is that the DP arrived in custody at 0255hrs but as stated, solicitor was not requested until 1520hrs (12hrs 25 mins later). However, there is clear rationale from the custody officers involved for this delay and is documented within very detailed care plans throughout detention. The 8 care plans document that the DP arrived intoxicated, in an agitated</i>

		state, diagnosed with mental health ailments, and actively making attempts to self-harm or assault officers throughout the first 6/7 hours of detention. Due to this, the DP remained on level 4 close proximity observations to ensure her safety. Rights and entitlements could not be completed because of this, and AA would be required. However, given the DP's demeanour, engagement with AA presented significant risk and would be extremely difficult. Once calm, after a significant period of detention, the DP was reviewed by HCP and deemed fit for detention and interview but would require AA. AA was requested following HCP review at 1120hrs, but a detention log entry evidences that due to resourcing issues with the AA provider, the AA attending would be travelling to Newtown from Pembrokeshire. No further custody processes could be completed until AA arrival, and this delay was not within the control of the custody staff. Once AA arrived, all custody processes were completed within a short period of time and DP was released. Custody Services deems that there is no delay between solicitor request and arrival, and the custody record contains a vast amount of detailed rationale behind
--	--	--

		<i>any other delays caused to the DP's release.</i> <i>Second custody record reviewed and, whilst there is a delay between request for solicitor and solicitor engagement with DP, there is a vast amount of information contained within the custody record on care plans and detention log entries providing rationale for this. The DP arrived at custody at 2022hrs and care plan documents that the DP is intoxicated, in an agitated state, and threatening officers. Despite this, the custody officer has established early rights and entitlements, and DP requested solicitor at 2044hrs. Custody notified the solicitor of this request at 2119hrs, but engagement with solicitor or interview not possible at that time due to DP's intoxication and demeanour. Over the next 6 hours, the DP's behaviour escalated whereby there were continued threats to officers, damage caused to the cell whereby the DP has flooded the cell and urinated over the cell floor, made attempts to self-harm requiring officer intervention, etc. The DP eventually went to sleep and was monitored via level 2 rousing checks. Once calm, at 0515hrs, the DP was reviewed by HCP who recommended AA. AA attended promptly at 0757hrs, rights and</i>
--	--	---

		entitlements were revisited with AA support. DP was arrested on suspicion of common assault and drunk and disorderly, then further arrested for criminal damage in custody. As there was no complaint forthcoming from the victim of the assault, the DP could be charged without interview for the drunk and disorderly and criminal damage, as there was sufficient police evidence to prove both offences. Due to this, solicitor would not attend custody but agreed to provide telephone advice which was done immediately before the DP was then charged and released from custody at 0825hrs. Whilst if you focus solely on time of request and solicitor attendance there is a delay, Custody Services disagree that this custody record lacks sufficient rationale to explain the delay. As evidenced within the above comments, the custody record contained a vast amount of information within care plans and detention log entries to fully understand the difficulties encountered, decisions made and to be able to audit this record without difficulty.
Detainees being offered food and refreshment regularly	One CISP member noted that the custody record indicated the detainee was held for approximately 9 hours and 48 minutes, but only two offers of	<i>Custody record review and Custody Services have located 4 occasions where the DP has been provided with either food, drink, or both. On the</i>

	drinks could be identified during that period. The member considered that the record did not clearly demonstrate that the detainee had been routinely offered refreshments throughout their detention, making it difficult to assess whether their welfare needs had been adequately considered and met. Another CISP member also noted that the detainee appeared to have been asleep for much of their detention and was only able to identify one occasion where food and drink were provided during approximately 16 hours in custody. While the detainee's sleeping status may have affected opportunities to provide refreshments, the member considered that the custody record did not clearly evidence ongoing consideration of the detainee's welfare needs or the provision of food and drink throughout their period of detention. Question to the Force: <i>Can the Force provide assurance that detainees are offered food and drink at appropriate intervals throughout their detention and that these offers are consistently recorded within custody records? Additionally, how does the Force ensure that the welfare needs of detainees who are asleep for extended periods are</i>	<i>first occasion, soon after arrival, the DP was provided with a cup of water. On the second occasion, 2 hours later, the DP was provided with pot noodle and squash. Shortly after finishing the pot noodle, the DP requested and was provided with some biscuits. On the fourth occasion 1 hour and 30 minutes later, the DP was provided with a cup of orange squash and a cup of water. Within that 3-hour 27-minute period, the DP was provided with 4 drinks, a meal, and a snack. Custody Services would consider this to be adequately meeting the welfare needs, specifically in relation to food and drink. The panel member has made an observation based on total detention time and number of "offers" (specifying only 2 offers when there were more) without considering any additional context. For example, the DP arrived at custody at 1640hrs heavily intoxicated, and his behaviour remained erratic for the next 3 hours. Within that time, the DP has made several attempts to self-harm in the cell by placing clothing around his neck which required officer intervention. Based on this, risk assessment meant that providing the DP with hot food or drink, or any additional items that could be damaged or used for harm could not be provided to ensure his safety.</i>
--	--	--

	<i>monitored and documented to provide a clear audit trail?</i>	<i>However, once calm, the DP was provided with the above-mentioned food and drink at frequent intervals. Regular checks of the detainee were maintained, with level of intoxication monitored, before then issuing the DP with an Adult Community Resolution when sober, and then his release from custody.</i> <i>Second custody record reviewed. The panel member observed that the detainee was asleep for much of their detention, which would have affected provision of food and drink, and that they were only able to identify one occasion where food and drink was offered. Custody Services have located four occasions where food and drink have been provided to the detainee. Water was offered on arrival but declined. The DP arrived agitated and aggressive, but behaviour then escalated with several self-harm attempts using clothing, making the provision of food and drink, particularly hot food/drink and additional items difficult based on risk. The DP then slept for 8 hours. When awake, the DP requested to see HCP and then spent the next 2 hours in HCP examination, completing rights and entitlements, and being processed. The DP was offered food and drink at this point but declined.</i>
--	--	--

		<i>The DP then slept for a further 2 hours. When awake the DP was offered food and drink and provided with tea and biscuits. The DP was then interview for 20 minutes. Provided with another cup of tea following interview. DP then went back to sleep before then being charged and released. During the total detention time of 16 hours, the DP was asleep for 10 hours, so within the remaining 6 hours, the DP was offered food/drink on 4 occasions, declining twice, and accepting twice. Custody Services consider this to be adequate consideration of welfare regarding food/drink.</i> <i>In relation to the above observations, and the additional question to the force regarding assurance that detainees are offered food and drink at appropriate intervals and how does the force ensure that the welfare needs of detainees who are asleep are monitored and documented, Custody Services believe that discussion with panel members would be beneficial to understand their expectations and perhaps manage those expectations.</i> <i>In both of the above observations, panel members have not been able to locate all occasions where food/drink has been offered which has affected</i>
--	--	--

		<i>their assessment of welfare needs being met. Additionally, total detention time has been assessed against number of offers of food/drink without considering context such as demeanour, intoxication, period of sleep, custody processes, etc. The comment suggests considering how often detainees should be offered food and drink by comparing expectations against normal eating and drinking patterns, and whether custody should warrant more frequent provision.</i> <i>The majority of detainees are monitored and engaged with at 30-minute intervals throughout detention, meaning that they come into contact with custody staff every 30 minutes, and if not "offered" food and drink, they are fully aware, following signing for rights and entitlements, that they can request food/drink and other items at any time during their detention. Following experience, if a person is hungry/thirsty, they will request food/drink.</i> <i>In relation to assurance that the welfare needs of sleeping detainees is considered, PACE dictates that ALL detainees (when required) must be afforded an uninterrupted period of rest to ensure that they are fit to</i>
--	--	--

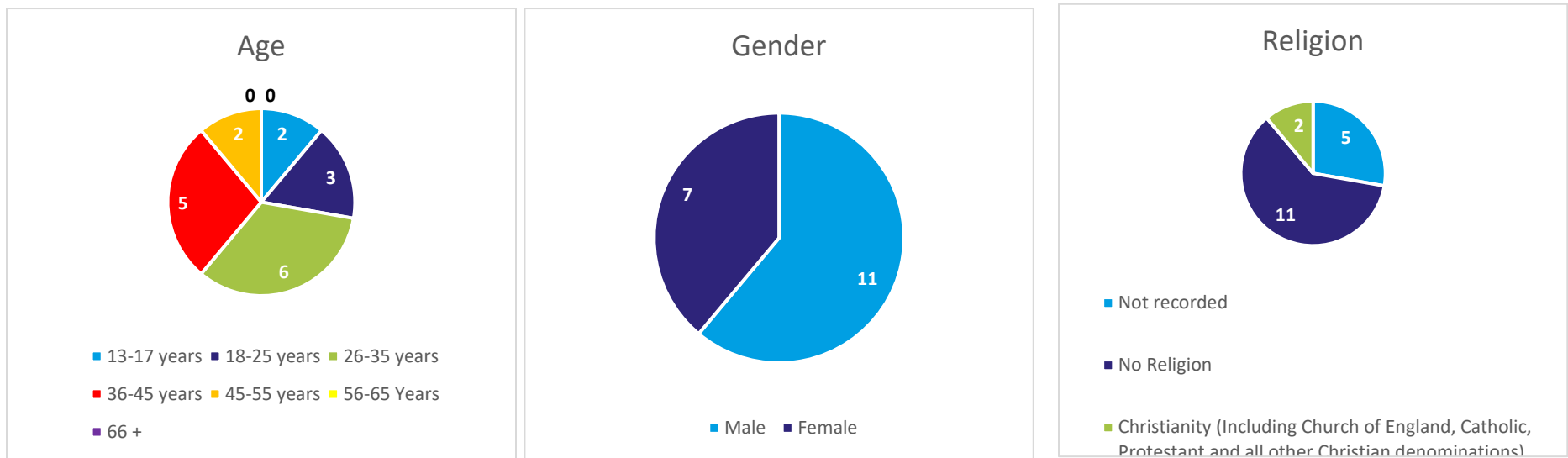
		<i>engage in custody processes such as interview, processing, etc. Due to this, custody staff cannot wake detainees to offer them food as this would interrupt their rest period, breach PACE, and potentially delay custody processes and their release. Of course, once awake, detainee welfare needs are always considered including food/drink, hygiene, exercise, etc.</i>
Female Officer Introducing themselves	The CISP identified two custody records where they could not find evidence that an allocated female officer had introduced themselves to the detainee. While this may have occurred and not been recorded, the absence of a clear record made it difficult for the member to verify whether the introduction had taken place in accordance with expected standards of detainee engagement and communication. Another CISP member identified that it was unclear if another female officer had been allocated during the period of detention. Question to the Force: <i>Can the Force verify whether officers introduced themselves to the detainees in these cases and, if so, provide assurance that such interactions are being consistently recorded within custody records to</i>	<i>First custody record reviewed and female officer was allocated and changed following shift handover. The detainee remained on level 4 close proximity observations throughout her detention, on a 2:1 ratio due to demeanour, and all observing officers were female. Whilst there is no dedicated detention log entry stating that the female officer introduced themselves, it can be assumed that as the female officer was sat at the cell monitoring the detainee in person, that the detainee had been introduced and spoken to the officers. Second custody record has been reviewed, female officer allocated and changed following shift handover. The first allocated officer was the female DEO who was present in custody and conducting 30-minute checks on the detainee, the second officer was a constable, and it states in the care plan that the officer is</i>

	<i>support transparency and effective scrutiny? Additionally, can the Force provide assurance that continuity of a female officer was provided throughout the detention of this female DP and that this was appropriately noted during the handover or replacement arrangements within the custody record?</i>	<i>present in the suite and speaking with the detainee. Again, whilst there is no dedicated detention log entry regarding introduction, the female DEO was in regular contact with the detainee, and the second officer's introduction is documented in the care plan.</i> <i>Custody record reviewed where panel member was unable to identify if another female officer had been allocated. This custody record involved one handover, and Custody Services can confirm that the allocated female officer changed following shift handover. Both allocated officers were the DEO on duty for that shift.</i>
--	---	--

Annex- Custody Record Review Findings

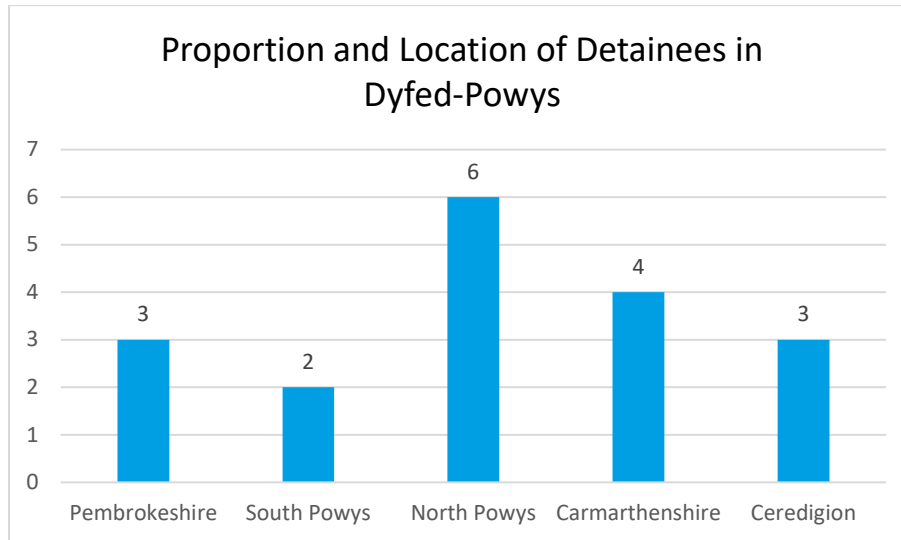
The data below outlines the results of the feedback forms completed by the CISP which were analysed to identify the strengths and areas for improvement in each specific area of custody with the focus on use of force in custody. This section of the report is supplemental to provide context to the *Summary of Findings* and the *Panel Observations* sections above.

Demographics



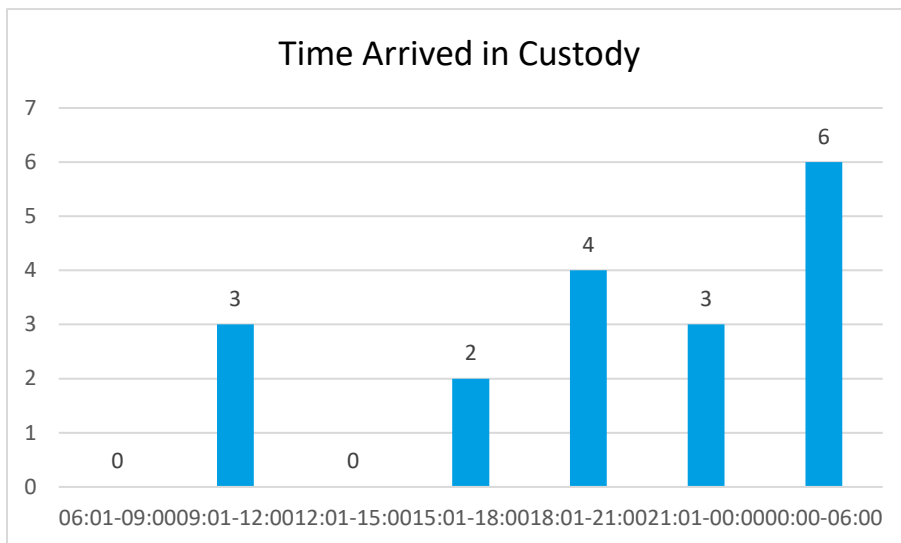
- The Ethnicity recorded for all detainees in this dip sample were all White British.
- There were no detainees over the age of 56 years old in this dip sample of custody records.

Custody Suites



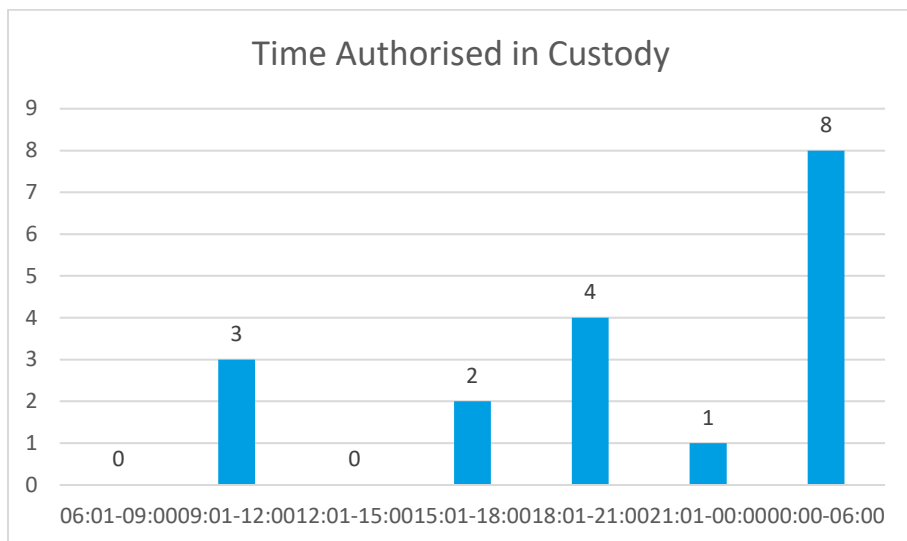
- Increased focus was placed on ensuring representation from all four custody regions within this scrutiny activity.
- Of the 30 cases prepared, each region contributed six custody records for Panel review.

Time Arrived in Custody



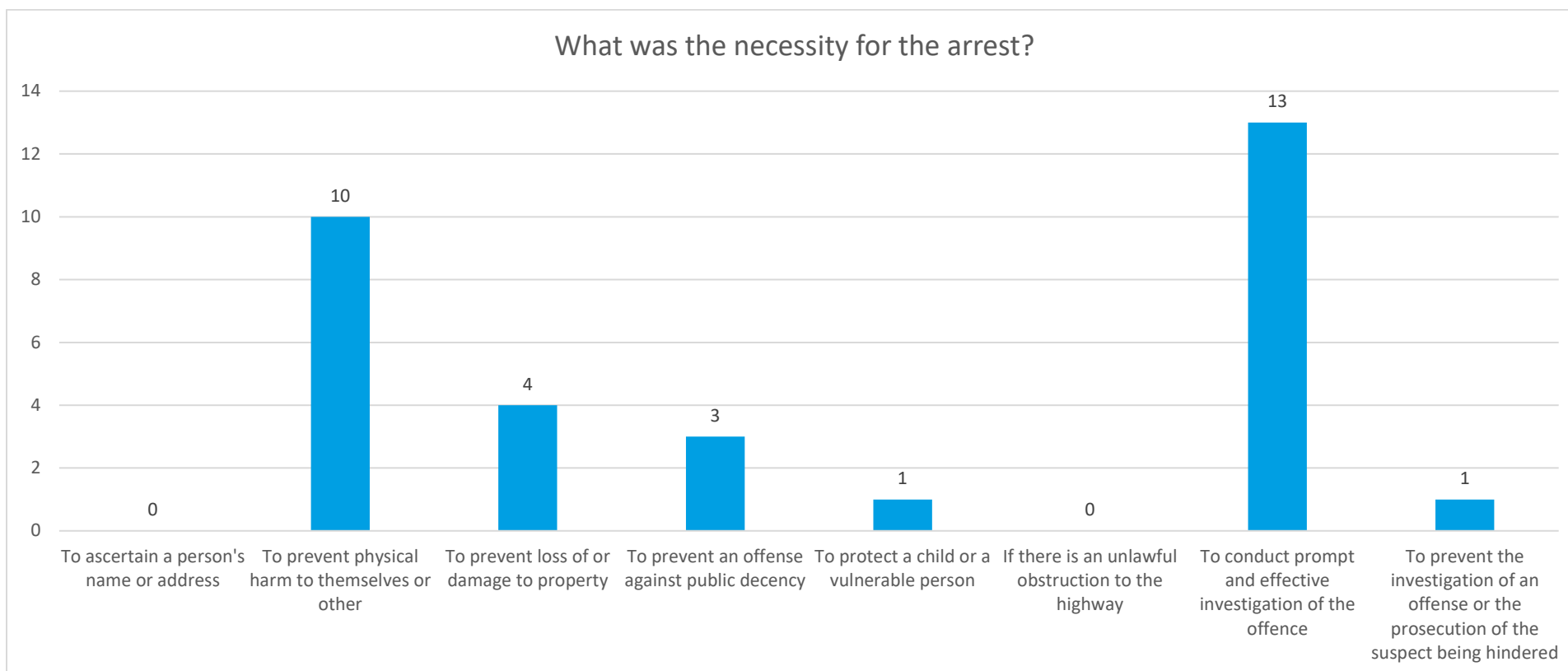
Time Lapsed from Arrival to Detention Authorised

- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 32 minutes.
- The highest waiting time was 1 hour and 38 minutes.
- The fastest time for a detained person (DP) to have their detention authorised was 6 minutes.



Total Time in Detention

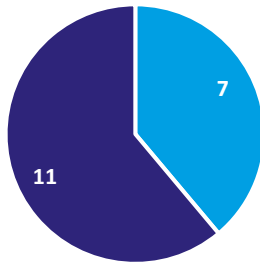
- The average time a detainee was held in custody was 14 hours and 25 minutes.
- The longest time a DP was held in custody was 1 day, 12 hours and 33 minutes.
- In contrast, the shortest time a DP was held in custody was 4 hours and 21 minutes.



- 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.
- 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* followed by *To prevent physical harm to themselves or other*.

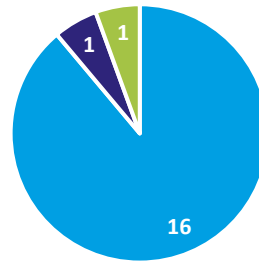
Provisions in Custody

Were religious requirements catered for?



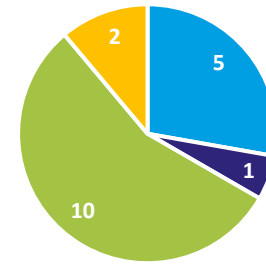
■ No ■ N/A (due to no religion)

DP was asked about dietary requirements and allergies?



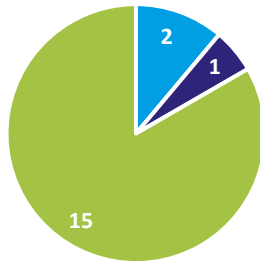
■ Yes ■ No ■ no detail found in record

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



■ Yes ■ No ■ No details found in record ■ N/A

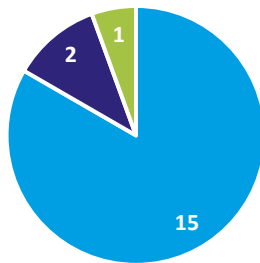
Was the DP instructed that the toilet is pixelated?



■ Yes ■ No ■ No details found in record

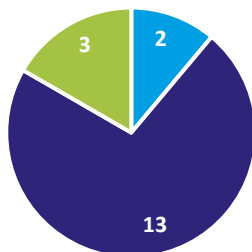
- The Panel specified that there were absences in the recording of religious needs, pixelation of the toilet and cell call button.

Food and refreshments offered regularly?



■ Yes ■ No ■ N/A

Was a distraction item provided or considered?



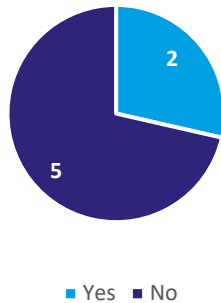
■ Yes ■ No ■ N/A

- The CISP specified the following with regards to food and refreshment not offered regularly:
 - The detainee only seems to have been offered two drinks during time in custody (Total Time in Custody 9 hours 48 minutes).
 - *Detainee seems to have been observed sleeping most of the time - I could only see one occasion of him being provided with food and drink in the 16 hours that he was in custody.*

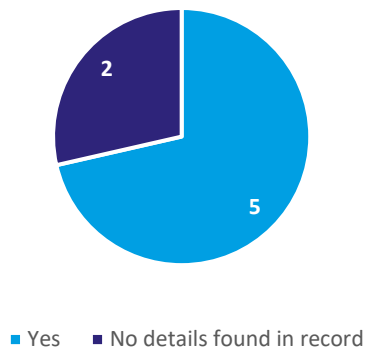
- A *distraction item* is a low-risk object provided to detainees to help reduce anxiety, agitation, or distress while in police custody. These items are particularly relevant for vulnerable detainees, including children, those with mental health needs, or individuals experiencing withdrawal or heightened emotional states. Examples of distraction items include:
 - Stress balls or fidget items
 - Colouring books and crayons/pencils
 - Reading materials (books, magazines)
 - Puzzles (e.g. word searches)
 - Soft items such as sensory aids (where appropriate)
 - More recently, computer-based tablets.
- The CISP specified that all distraction items that were provided to detainees, showed evidence of being appropriately risk assessed.

Female Detainees

Is the allocated female officer the same officer throughout the DP's detainment?



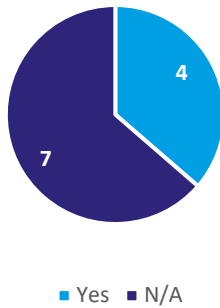
Did a female officer introduce themselves to the DP?



- The CISP identified that all 7 female detainees were assigned a female officer.
- This CISP also identified that:
 - All DPs were offered menstrual products
 - All female DPS were asked if they would like to speak with someone of the same sex.
- CISP had the following comments with regards to the overall treatment of female detainees:
 - There was a continuous rotation of named officers across the shift and the DP was monitored consistently by female officers.
 - A female DP states that they are pregnant, but tests disproved this. The same DP stated that she is bleeding vaginally and has a broken thumb. She was subsequently taken to hospital and returned to custody having been checked by Hospital staff.
 - It was unclear if a female officer was available throughout the period of detention. Whilst the Detention Escort Officer (DEO) was allocated and entries show her engagement with the detainee for a time; thereafter, it is unclear if another female officer has been allocated or not.

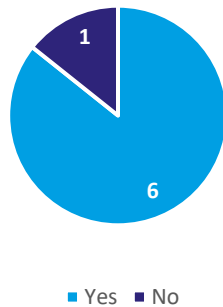
Hygiene

Does the record make any reference to hygiene requests being made? (Male)



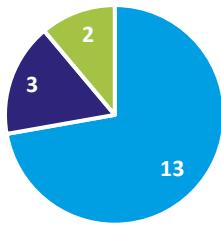
- The CISP identified no concerns in relation to hygiene or any general requirements for detainees.

Does the record make any reference to hygiene requests being made? (Female)



Rights and Entitlements

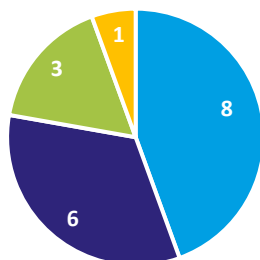
Was there a delay in receiving R+E (e.g. with AA/interpreter present) of more than 1 hour?



■ Yes ■ No ■ N/A

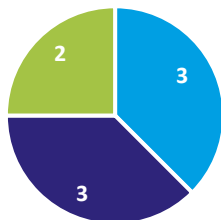
- All DPs were given their rights either at booking in stage or at a later stage during their detention.
- Those DPs that did have a delay in receiving their rights and entitlements were due to the following factors:
 - Aggressive behaviour
 - Challenging and non-compliance
 - Intoxication
 - Delays in Appropriate Adults attending

Did the DP see or speak to a Solicitor?



■ Yes ■ No ■ No details found in the record ■ Amh

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



■ Yes Rationale Given ■ No Rationale Given ■ N/A

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

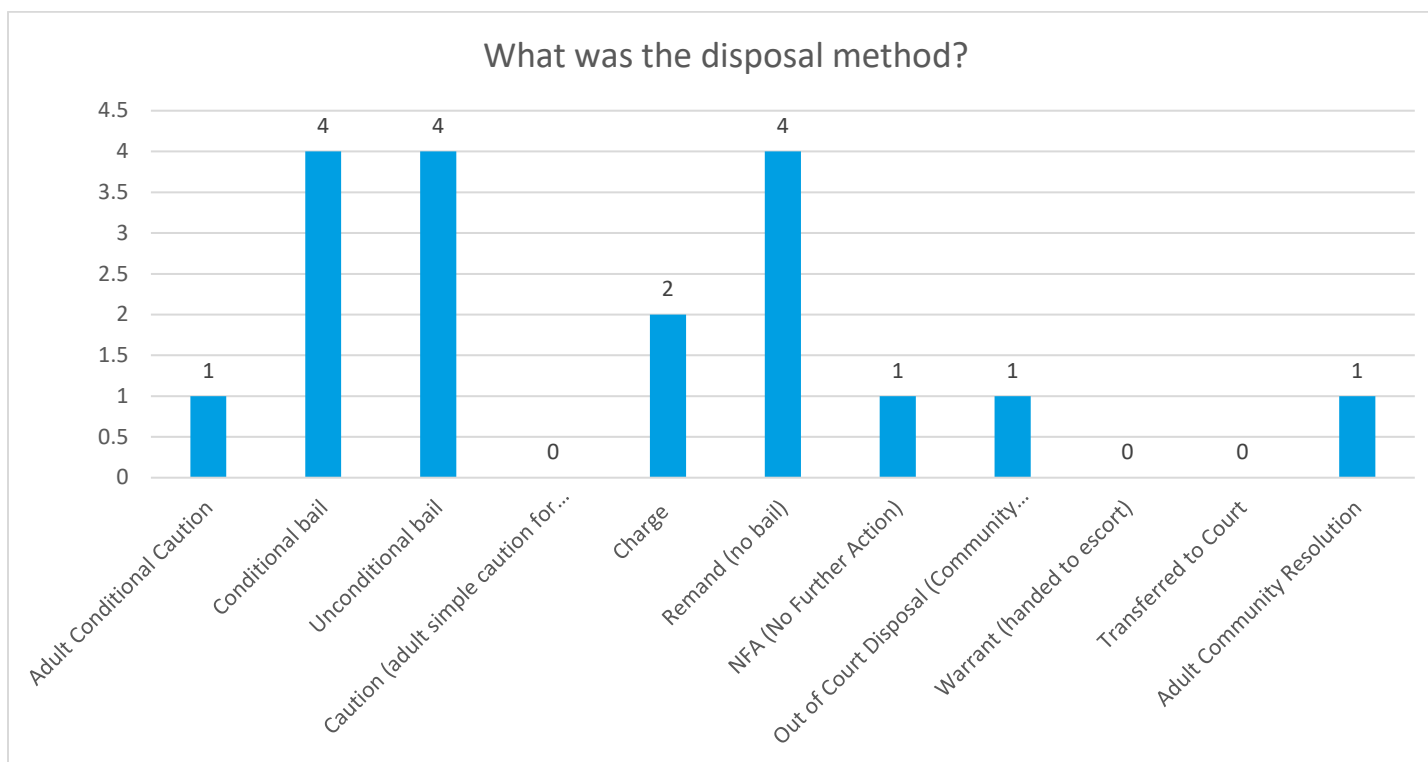
- The average time for a detainee took to request a solicitor was 3 hours and 39 minutes.
- The longest period for a DP to request a solicitor was 8 hours.

The length of time taken for police to contact a solicitor

- The average time taken was 1 hours and 45 minutes for police to contact an on-duty solicitor.
- The longest period of time was 7 hours.

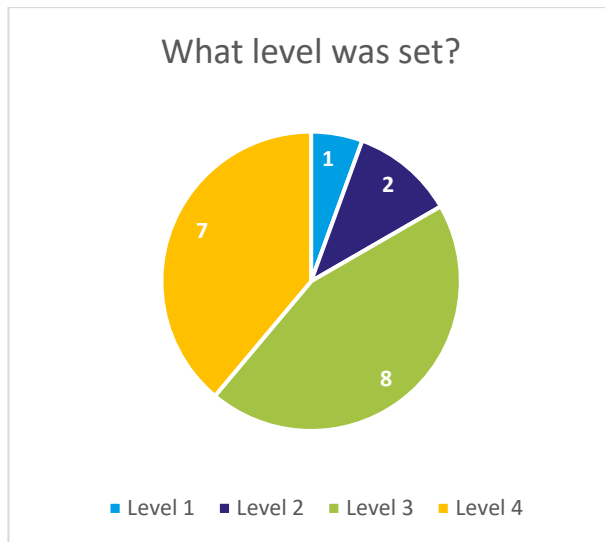
The length of time taken for solicitor to arrive from the point of being contacted

- The average time it took for a solicitor to arrive after being requested was 7 hours and 34 minutes.
- Two CISP members found the record unclear to verify solicitor involvement.
- All solicitor advice was given in person.
- The CISP referenced that:
 - The delays in legal representation were due to the DP's behaviour and/or intoxication.
 - Four instances where DPs declined the option of legal representation.
 - DP's own firm were unable to attend and they declined the option of the duty solicitor.
 - The duty solicitor was seeing 6 other DPs, which resulted in the delay.



- The Panel were asked to note the disposal method to assess whether detainees, subjected to use of force in custody, were detained proportionately to the necessity of arrest.
- As can be viewed, the disposal is spread across a wide range of methods with only one referencing NFA.

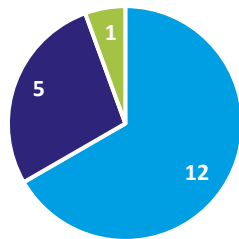
Observation Level



- All custody records reviewed had their observation level set and all were adhered to.
- 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).
- Of the two custody records that were set at level 2, there was evidence to check that DPs were on rousal and adhered to.
- The CISP had the following comments to raise about the observational level:
 - Good evidence of rationale for downgrading and upgrading levels regarding the risk assessment.
 - A number of DPs displayed challenging, violent and aggressive behaviour towards staff and themselves.
 - One CISP member noted that the recording of observation and care plan levels was not always clear or consistent within their custody record. In several instances, entries appeared to reference different observation levels simultaneously or described observation practices that did not obviously correspond with the level recorded. This created ambiguity regarding the detainee's actual observation status and made it difficult to determine whether the level of monitoring was accurately documented and consistently applied.

Support Services

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

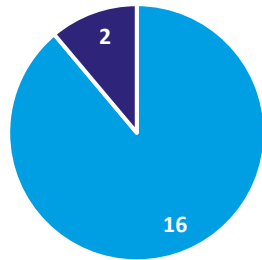


■ Yes ■ No ■ N/A

- 67% of DPs were offered support services in comparison to 28% who were not and 1 record that this was not applicable.
- For those that were not offered support services, the CISP noted the following reasons:
 - Declined by DP.
 - Provisions were already in place.
- Panel members noted that the majority of support referrals made were for Mental Health.

Healthcare Professional (HCP)

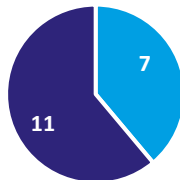
Did the DP see a healthcare professional?



■ Yes ■ No

- The Panel noted the delay for a DP to see a HCP were due to the aggression displayed by the detainee.
- CISP found evidence of caring, detailed and effective custody records.
- Custody staff seem to recognise Mental Health concerns, but experienced difficulty in assessing this due to the DP's refusal to answer the risk assessment questions.

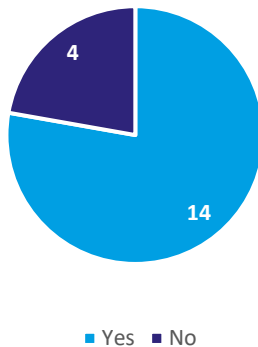
Was there a delay in healthcare professionals attending and DP receiving a health assessment?



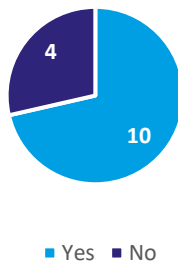
■ Yes ■ No

Use of Force

Was force used in the custody suite?

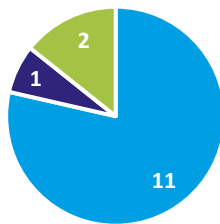


Was the use of force necessary, proportionate, and reasonable given the circumstances?



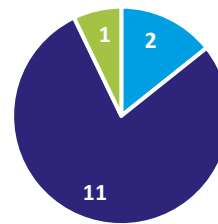
- The CISP were asked if there had been any behaviour or circumstances that led to the use of force being used. The CISP specified the following:
 - The detainee initially engaged well however was erratic, unpredictable and appeared to be seeking confrontation.
 - DP was disruptive and screaming and wanted to go home. Could not be reasoned with and was taken back to cell.
 - DP spitting and very violent and hostile.
 - Self-harm.
 - Under the influence and aggressive.
- One CISP member noted that the custody record does not clearly establish whether force was used during detention or whether handcuffs were applied solely at arrest and subsequently removed in custody. Furthermore, no time has been recorded for the removal of the handcuffs, with the field at 01:22 BST ("If handcuffs, time handcuffs removed:") left blank. This limits the audit trail and makes it difficult to determine the extent and duration of any use of force.
- The CISP noted that the most prevalent tactic of force used in custody was handcuffs, following by Open hand technique (push, punch, grab), and prone restraints (on floor restraint).
- There were 4 instances where the CISP judged that the application was not necessary and proportionate, and that the rationale was not sufficient and an additional 4 could not find a use of force entry in custody.

Do you consider the rationale provided for the use of force to be sufficient?



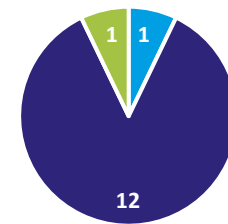
■ Yes ■ No ■ N/A

Were there any injuries obtained by the DP as a result?



■ Yes ■ No ■ N/A

Were there any injuries obtained by custody staff as a result?



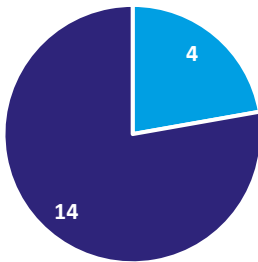
■ Yes ■ No ■ N/A

The CISP specified the following observations in relation to use of force in custody:

- *Good understanding of young person. Could improve recording of how taken back to her cell and what force was used.*
- *No injuries caused by UoF, but DP had injuries due to banging head on van cage on route to custody and possible self injuries whilst in cell.*
- *Record says "Whilst in the cell use of force us been used to restrain the DP whilst items were removed." There could have been more detail provided as to how the D/P had been restrained.*
- *Only concern is recording - or possible lack of it - as it seems likely that force had been used when clothes were removed.*
- *Recording of what force used and when unclear to make comment*
- *The good practice was the working together and trying different methods of distraction. No to a shower but reasoned why. Providing crayons and paper for distraction.*
- *Concern about Inspector's review which specifies that 'There has been no use of force whilst at custody'.*

Strip Search

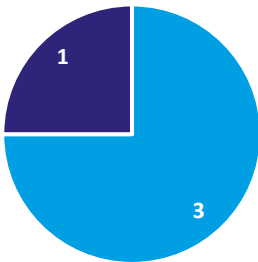
Was the detainee strip searched?



■ Yes ■ No

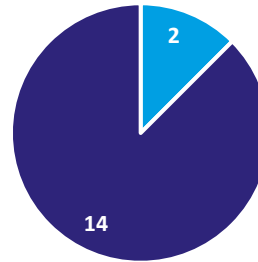
- In all four records, it was unknown or unclear whether the DP had been advised that the CCTV was either obscured or turned off for the purposes of the search.
- In CISP member was uncertain of the rationale provided for the strip search; however, for the other three recorded, they were content and determined the rationale to be acceptable.

Was there a good rationale for strip search?



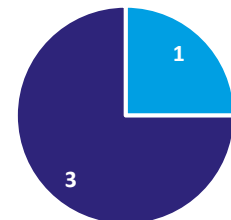
■ Yes ■ No

Was the detainee strip searched?



■ Yes ■ No

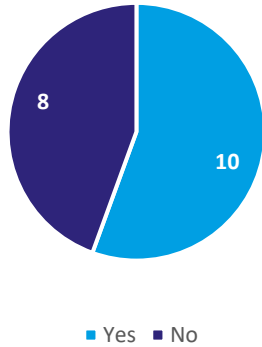
Was there an Appropriate Adult present during the strip search?



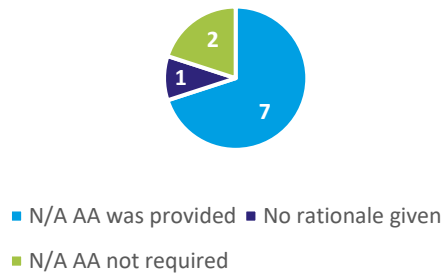
■ Yes ■ No

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

Did the Force identify that an AA was necessary?

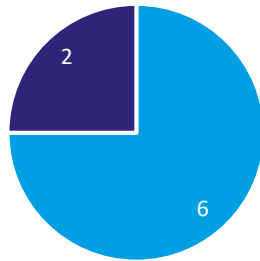


(If yes and one wasn't provided) Was there any rationale as to why an AA was not provided?



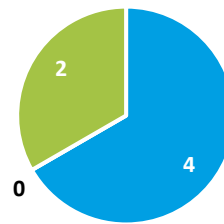
- The average time for a detention officer to make contact with AA was 7 hours and 48 minutes, and the average time the DP first made contact with an AA was 1 hour and 26 minutes.
- The longest period was 12 hours, in contrast the shortest was 4 hours. The CISP specified the following rationale for the delay:
 - Required to wait until the DP had sobered up from being intoxicated.
 - DP was sleeping due to time of arrest.
 - Travelling distance for the AA to arrive.
 - DPs reluctance to answer risk assessment questions.
- The Panel noted the following reasons other than being a child, why these detainees had additional vulnerabilities:
 - Neurodiversity
 - Substance misuse
 - Mental Health/Psychosis
 - Medication for physical debilitating injury.
 - History of self-harm
 - Epilepsy
- A CISP member noted that the Force had identified that AA was required but during the handover, the custody sergeant was informed that the AA was not required for custody process. This person was subsequently charged and sent straight to Court without any AA to ensure her understanding of what is happening. The CISP member noted that this individual had been specified as having bipolar/depression and also a number of physical health issues including arthritis.

Was the nominated person/AA contacted?



■ Yes ■ No

Was there any rationale available for a delay in AA's arrival?



■ Rationale given ■ No rationale given ■ N/A

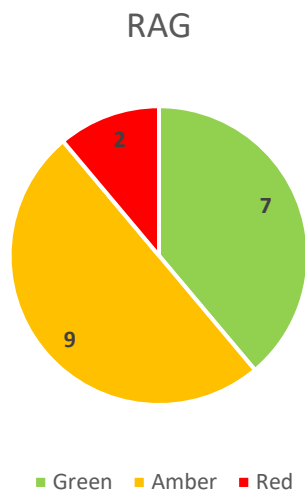
Children in Custody

- Of the two children that were detained in custody:
 - All children's checklists were completed.
 - All appropriate inspector reviews had taken place.
 - Both children were kept overnight with alternative care sought for one and the other was unable due to the refusal of the care provider.
 - The Voice of the Child were recorded.
- One Reachable moment interview did not occur due to limited availability of youth worker. The OPCC is aware that an uplift in staffing of Reachable Moment workers is currently underway.
- The CISP members did not raise any concerns with regards to this aspect of this

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
"Correct use and level of force used in this instance"	"Good practice seen throughout the DP detention. Good use of children's care plan and reachable moments, levels, AA, flexible to DP changing presentation. What lets this case record down is the clear record of young person being taken back to her cell. Use of force needs to be clearly outlined"	"There is no clear picture to say what force used, that inspectors aware of what used . It is concerning that a range of force used at different times and no clarity. This situation does require further scrutiny within the force"
"officers taken all action to protect the DP and themselves"	"More detail as to the method of restraint could have been recorded."	"no rationale given in relation to time Solicitor requested (14:23) to time solicitor arrived (17:51)."
"Officers in a very difficult situation when DP refused Risk Assessment."	"Ambiguity in records whether force was actually used in custody, Inspector says no force used in custody."	
"overall good practice with a challenging DP"	"Inspectors use of 'No use of force' declaration seems to be at odds with the rest of the record."	