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

This document is available in Welsh as well as English.

Custody Independent Scrutiny Panel: Vulnerable Detainees

May 1st 2026

Police and Crime Commissioner for Dyfed-Powys
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Contents

Introduction

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

In May 2026, the CISP focussed on Vulnerable detainees. In preparation for this scrutiny activity, the Panel were reminded of the *Summary of Findings* from last year's report which can be viewed here.

The management of vulnerable detainees in police custody continues to be a national area of focus. This is well established and supported through legislation, inspection frameworks, professional guidance and independent scrutiny. The expectation is that police forces identify vulnerability at the earliest opportunity, safeguard detainees' rights and welfare, and ensure that all individuals are treated with dignity and humanity whilst in custody. Particular emphasis is placed on children and adults with mental health needs, communication difficulties or other factors that increase vulnerability.

It is widely recognised that a disproportionate number of detainees present in custody with mental ill-health, learning difficulties or neurodivergent needs. In many cases, this is further compounded by alcohol or drug intoxication. There remains ongoing national concern regarding the use of police custody in circumstances where health-based provision or diversion pathways would be more appropriate, in line with the "Right Care, Right Person" approach, as highlighted by the Association of Police and Crime Commissioners (APCC – Mental health and custody).

National inspection and oversight bodies, including Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and the Independent Office for Police Conduct (IOPC), have continued to identify inconsistencies in the way risk is assessed and managed in custody. This includes both initial risk assessments and the ongoing monitoring of detainees, particularly

where an individual's condition deteriorates during detention. Common issues identified include inappropriate observation levels, poor quality cell checks and an over-reliance on detainee self-disclosure of risk, as set out in IOPC learning reports (IOPC – Learning the Lessons, Issue 42).

Children and young people remain a key area of concern. National reviews consistently identify police custody as an unsuitable environment for children, particularly those with prior trauma or care experience. Ongoing concerns include children being detained for extended periods, delays in securing an appropriate adult, and the use of custody in circumstances where it should be a last resort, as highlighted in the All-Party Parliamentary Group for Children in Custody report (APPG Children in Custody – Executive Summary).

The purpose of this scrutiny is to review how vulnerability is identified, assessed and managed within police custody, and to provide assurance that the detention of vulnerable individuals is necessary, proportionate and conducted in line with expected standards. This scrutiny was undertaken through a dip sampling process of custody records provided by the Force. A total of 30 cases were selected, consisting of 15 cases involving adults and 15 cases involving children. The cases were selected to provide an overview of current practice in relation to vulnerable detainees and to identify both areas of good practice and opportunities for improvement.

Findings from this review are intended to support transparency, identify learning, and contribute to ongoing improvement in the management of vulnerable detainees in police custody. Here is an example of the set of questions the Panel were asked to consider:

QR code: **Link:** Custody Independent Scrutiny Panel (01/05/2026) Vulnerable Detainees – Fill in form

Summary of Findings

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

Positives:

Rights and Entitlements

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

Appropriate Adult

- The average time for a detention officer to make contact with AA was 46 minutes, and the average time the DP first made contact with an AA was 1 hour and 26 minutes.
- Most delays were justified by contextual factors, including:
  - Intoxication
  - Out-of-hours conditions
  - Family availability
  - Pre-arranged attendance

Total Detention Time

- The average time a detainee was held in custody was 9 hours.
- The average time a juvenile detainee was held was 6 hours and 17 minutes.

Use of Force

- In all three instances the CISP identified use of force in the custody suite, they judged that the application was necessary and proportionate, and that the rationale was sufficient. No injuries had incurred to both staff nor the detainee.

Support Services

- 56% of detainees were offered support services; 25% were not; 19% not applicable.
- Custody Services consider this an acceptable and sufficient level of provision.
- Referrals and signposting are **monitored monthly** and show consistent use.

Female Officer Allocation

- All female detainees were allocated a female officer and these were accurately recorded.

Areas for improvement:

Gaps in Information Recording

- The recording of toilet pixelation, cell call bell or religious items is not routinely recorded on custody records.
- Only 19% of records documented that detainees were informed of toilet pixelation; however, this is stencilled on the cell walls for the detainee's knowledge. Whilst Custody Services are also confident that this is being communicated to detainees verbally, there is persistence in poor recording compliance.
- This is hoped to change with the development of a Detention Officer mobile app in development which will help:
  - Improve real-time recording
  - Introduce prompts for required information.
  - Increase consistency and auditability.

Distraction Items

- No standalone risk assessment template exists for distraction items.
- Whilst all detainees that received a distraction item were considered suitable based on the information in the care plan, given the varied risks associated with different items, this may be something the Force considers improving clarity and visibility of that risk assessment. Current guidance is being considered for the use of tablets in custody regarding the accuracy of recording and risk assessment, is this applicable to other items too.

Legal Representation

- There are recordings of solicitor presence in interviews but there are gaps in arrival times or consultations. It is understood that the Police computer database; known as Niche, does not prompt custody staff for these entries.

Strip Search Procedures

- Inconsistent recording of whether detainees were informed about CCTV status.

Children In Custody (Voice of the Child & Reachable Moments)

- Some gaps in Reachable Moments and Voice of the Child being accurately recorded on the Children's Checklist by custody staff. There have also been gaps where the Voice of the Child has not been recorded at all, despite this being a requirement.
- Difficulties associated with staffing in relation to Reachable Moment workers meaning that they have not been available for every child that has been held in custody; however, there is due to be an uplift of workers in the immediate future.
- Due to the geographic area of Dyfed-Powys, it has been agreed that a child held in custody for up to 3 hours will not see a Reachable Moment worker, due to travel and the limited opportunity to have meaningful engagement will be too challenging in a short period in custody.
- There was one instance of a missing inspector review of a child in custody, that includes a 2 hour child inspection review and a 6 hour PACE inspector review.

Panel Observations

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

Theme	Observation	Force Response
Support Services	Given that 56% of detainees were offered support services, compared to 25% who were not and 19% where this was not applicable, are you satisfied with this level of provision, particularly considering the thematic focus on vulnerable detainees?	*Yes, this is a sufficient return regarding support services offered. Data regarding signposting and referral to support services is monitored monthly within the medical contract performance meeting and data can vary from month to month. This data displays a high frequency of signposting and referrals across all categories of detainee. It must be considered that the level of vulnerability will be individual to each detainee and so not all "vulnerable" detainees will require support services post custody. A further variable to consider is that a detainee may already be receiving support from a partner agency, relevant to their needs, and so further signposting and referral is not necessary on these occasions.*
Distraction item	The CISP specified an absence of a risk assessment for all 4 records that recorded distraction items being provided to a DP. Can this be verified and can you advise if there is any learning that can be attributed to this?	*I suspect that my explanation of risk assessing distraction items may have been misinterpreted which is an error on my behalf. Custody Services has not created a specific risk assessment for the issue of distraction items, but the suitability of items being provided*

		to detainees can be assessed via risk assessments and care plans created. *In each of the four custody records highlighted, all detainees were suitable to receive distraction items based on the information recorded by the custody officer within the care plans created.* *In relation to the recently introduced Samsung A9 tablets, Custody Services recently created and disseminated a guidance document regarding their use in custody. Link attached to document for transparency - Distraction Tablet Guidance. Custody Services are considering the introduction of specific templates to be completed regarding the provision of distraction tablets to improve compliance and accuracy of recording and risk assessment.* *The provision of any distraction item MUST be risk assessed by the custody officer on every occasion. Items must not be issued to any detainee who is intoxicated, displaying violence or aggression, there are active concerns regarding self-harm, or any other reason/s that may temporarily prevent their issue.*

Female Officer Allocation	A CISP member identified that a female officer was not allocated for the female DP juvenile. Can this be verified and clarity provided?	*Custody record has been checked, and a female officer was allocated and documented within all care plans on the custody record. The first care plan completed at 19:47hrs evidence this. The allocated female officer remained the same person throughout detention as the detainee was only in custody for a short period and no handover of custody staff took place.*
Legal Representation	1) CISP member had difficulty ascertaining whether a DP saw or spoke to a solicitor despite requesting for one. Can you provide assurance that the DP was offered and saw a legal representative? 2) Another CISP member has posed the query why a 4 hour delay incurred in contacting a solicitor after they had indicated that they are requesting one? 3) A further record could not ascertain if the DP spoke with the solicitor. Is there a gap in the recording of the arrival of a legal representative?	*1. Custody record checked and the interview summary highlights the presence of a solicitor. However, there is no detention log entry highlighting solicitor arrival time at custody and no transfer to consultation with solicitor. Feedback will be provided to the custody officer in question.* *2) This custody record may have been difficult for the panel member to assess the timeline of events as the detainee had been arrested and street bailed several days before and then answered bail resulting in the creation of this custody record. Due to this, solicitor attendance had been*

		prearranged and a detention log entry at 1659hrs highlights that the solicitor arrived at the station prior to the detainee and was placed in the solicitor's room awaiting disclosure from officers. There are further entries stating that officers are providing disclosure to the solicitor, the detainee being transferred to the solicitor room for consultation, and the detainee being transferred for interview with solicitor present. Therefore, there was no 4-hour delay. The detainee was also only detained for a total of 2 hours 16 minutes and so a 4-hour delay would not be possible. *3) Custody record checked, and I can confirm the panel members observation that there are no detention log entries highlighting solicitor arrival time, transfer of the detainee to the solicitor's room for consultation, etc. Feedback will be provided to the custody officer in question.*

		Custody records 1 and 3 highlight an ongoing issue with the recording of solicitor arrival time and transfer of detainees to the solicitor's room for consultation. Whilst compliance in this area has improved, there are still gaps in recording. Niche does not provide prompts regarding these entries and so it relies on custody officers to remember to complete these entries. Custody Services will discuss this with BCU Custody Inspectors and ask for this area to be driven with their staff.
Detainee on Rousal Checks	A CISP member could not identify if the DP on level 2, received rousal checks.	*Custody record checked, and the detainee was on L2 observations from arrival in custody at 05:54hrs until observation level was changed to L1 30 at 08:42hrs. During that time, 7 detainee welfare checks were completed and recorded. During 3 of these checks the entries state that the DP was awake and spoken with, and on the other 4 occasions the entries highlight that the detainee was woken and spoken to.* *Custody Services has recently created a guidance document regarding observation levels to ensure all actions are completed and*

		documented by custody staff. This includes ensuring L2 obs checks are compliant with the 4 R's (Rouse, Response to questions, Response to commands, Record), and that L3 and L4 constant obs are being conducted in the correct manner. This document is currently under review/approval and has not yet been disseminated to custody staff. *Document attached for transparency - Custody Observation Levels Guidance Document.*
Strip Search	In neither record reviewed, where a strip search occurred, could either CISP member identify whether CCTV was advised to the DP as being obscured or turned off for the purposes of the search.	*Both custody records checked:* *The first custody record there is no accompanying entry to state that the detainee has been informed that CCTV is obscured or turned off.* *The second took place in Dafen, which is the only custody suite which has a dedicated search room with no CCTV installed, and so there is no requirement to advise the detainee that CCTV is obscured from view.* *This additional element to strip searches in custody, and its recording, continues to be sporadic with compliance between custody officers. At present, there is no prompt for this action and Niche does not include CCTV within the strip search authority template. Consideration will be given to submitting a request for change to Niche for this to be included.*

Appropriate Adult	There were 5 records where the CISP could not identify a rationale for the delay in AA's arriving at custody. Are you able to provide any context to this?	*All custody records checked:* *The first detainee arrived at custody at 06:09hrs and was intoxicated. The observation levels were not changed until 4 hours later at 11:09hrs, rights and entitlements were then completed when sober, and AA was notified at 11:09hrs with the request made to Adferiad (AA provider). AA then did not arrive until 15:07hrs. I am unable to clarify whether the arrival time being several hours later was due to AA availability or whether the request had been booked for that time.* *The second custody record, as highlighted in a previous observation, may have been difficult for the panel member to ascertain the timeline of events as the detainee was subject to street bail. Due to this, the solicitor and AA were pre-booked for the detainee's bail return time with both arriving at custody prior to the detainee. This is evidenced within the detention log and rights and entitlements where the AA is documented as being from the Youth Offending Team and arrival time documented as the same time as the custody record was created. There was no delay in AA arrival on this record.*

		The third record, the detainee arrived at custody at 20:34hrs. The booking in procedure took over 1 hour, due to the demeanour of the detainee and not engaging with the risk assessment, and the first care plan was completed at 21:42hrs. During this time, custody staff were in conversation with the detainee's mother to inform her of the detainee's arrest and to ask if she is available to attend custody to act as AA. This is documented at 22:07hrs, as well as the mother's refusal to attend custody to act as AA. Due to this custody episode being out of hours, Emergency Duty Team (EDT-out of hours social services) had to be contacted to request Social Services attendance for AA purposes, and this request was made at 22:45hrs. Social Worker then arrived at custody 30 minutes later at 23:15hrs. Therefore, AA arrived at custody 2 hours 41 minutes after the detainee's arrival. I would not consider this a delay, especially considering the context provided above and actions completed by the custody staff. *The fourth record, the detainee arrived at custody at 06:10hrs and required a period of rest due to being awake throughout the night. This is*

		documented within the care plan and evidenced within the detainee welfare checks which show the detainee is sleeping for several hours. Despite this, efforts were made to notify the detainee's mother of the detainee's arrest but, due to the time of day, contact was not made with mother until 07:42hrs. Detainee's mother was then contacted and requested to attend custody at 10:40hrs when the detainee woke. However, the mother did not arrive until 12:15hrs. *The fifth record, there is no delay in AA arrival. The detainee arrived at custody at 08:58hrs. The detainee's father was notified and arrived at custody at 09:22hrs, 24 minutes after the detainee's arrival.*
Children in Custody	1. There was one instance where Reachable Moments was not completed on the premise that there were no youth workers available. Is this correct; and if so, are there any assurances that this will not be a persistent issue for juveniles in custody? 2. There were two instances when Reachable Moments were not completed based on how long the child DP was detained in custody. Is this justified? In the same record, staff did not	*1. Unfortunately, Adferiad resourcing of requests for Reachable Moments Workers (RMW) has been slightly sporadic in recent months. This can be attributed to both the number of RMWs employed/available as well as the recent increase in the number of children in custody and thus the increased demand for RMWs. However, Custody Services continue to work closely with Adferiad regarding this pilot and monitor requests vs attendance in monthly performance meetings. Reassurance*

	complete the Voice of the Child on the premise that the child was awaiting to see the Officer in Case (OIC) and the HCP. Can you provide clarity whether all children, who have their detention authorised, should expect to have their VoC and reachable moments recorded? 3. Two records specified that VoC had not been completed with no reasoning specified and a further VoC was not completed on the premise that the child needed to see a HCP.	*can be provided that three additional RMWs completed their training at the beginning of May and a further 7 will complete their training today (27th May). This increase of 10 further RMWs to the cohort already available will assist in keeping missed requests to a minimum.* *2. In relation to Reachable Moments not being completed due to length of detention. I am unclear whether this is in relation to the Reachable Moments Worker attendance or the Reachable Moments section of the Children in Custody Checklist. Therefore, I will clarify both areas. In relation to Reachable Moments Worker attendance, Custody Services has agreed that if the detainee is only likely to be detained for 2-3 hours, then no request needs to be made for RMW attendance. This decision has been made as, taking into account custody actions that need to be completed (interview, processing, etc), the time to request and allocate a RMW, and the geography of the force meaning travel time is highly likely, then meaningful engagement between child and RMW will not be possible for short detention periods. Custody cannot continue to detain, or delay release, purely for RMW to attend. This was the case for both*

		custody records highlighted where detention periods were short. *In relation to VOC and Reachable Moments being completed, VOC should be completed on every child checklist completed. This is for custody staff to document their opinions/views following their engagement with the child. The caveat to this is that only three of the AWARE Principles can be completed in custody which are Appearance, Words, Activity. The remaining two principles (Relationships and Environment) cannot be completed in custody as they are geared towards attendance to initial calls, and attendance at addresses, where the child's relationships with those present and the environment (cleanliness of the home, food available, etc) can be assessed.* *The Reachable Moments Project was introduced as, it is nationally agreed, that police officers should not be completing this action as police officers do not have the relevant training or experience to engage successfully with children for this purpose. Thus, it should be completed by trained professionals who have experience of working with children in a supportive role.*

		However, if RMW attendance is not possible, this section of the child checklist should still be completed by custody officers based on the information they have available. *Feedback will be provided in relation to this matter.* *3. VOC should always be completed on all child checklists as highlighted in the response to point 2.*
Red RAG	CISP member advised that the record that they oversaw, did not have inspector reviews nor an Operational Sergeant (non-custody) reviewing the arrest. Can you advise if this the case; and if so, if there is any learning that can be provided from this custody record?	*Custody record checked, and I can confirm that the panel members observation regarding the additional inspector reviews is correct. Within this custody record, the additional inspector review for children at hour 2 should have been completed. In addition, the 6-hour PACE inspector review was also not completed. Feedback will be provided to the custody staff and inspector on duty.* *In relation to an operational sergeant (non-custody) reviewing the arrest, this was never agreed to be documented within the custody record and was introduced to ensure early scrutiny of child arrests for alternative options to be considered other than custody. This action took place outside of custody and there was never requirement for this to be documented on the record by the*

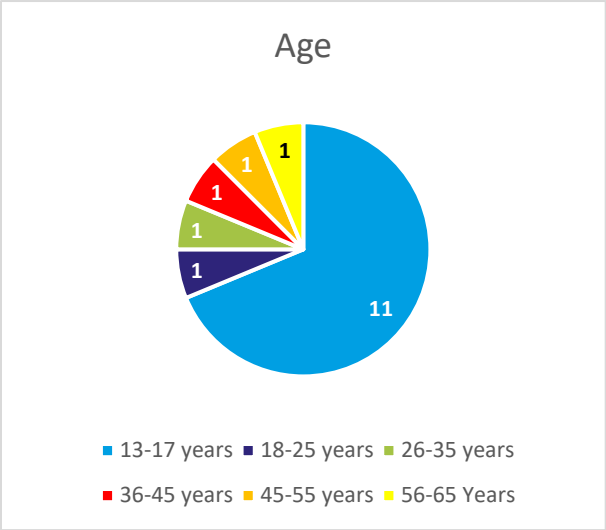
		operational sergeant or custody officer. However, this process of operational sergeants reviewing child arrests is soon to be amended following evaluation. It has been agreed by chief officers that this process will now be completed within the new Pre-Custody Triage. The Pre-Custody Triage will be completed by arresting officers, via a template, and has numerous areas of risk to consider which are RAG rated. Children have been placed in the amber section of the RAG rating, meaning that this will mandate conversation between the arresting officer and the custody officer prior to them travelling to custody. The custody officer will then hold discussion with the arresting officer to ensure all alternative options have been explored and that it is necessary and proportionate to convey the child to custody.
Toilet Pixelation	Given the national news on the toilet pixelation scandal in an English Force, the CISP has only identified 19% of records reviewed that recorded that the DP had been notified that the toilet area in the cell is pixelated. Can you advise if this is an area that the Force intend to improve on moving forward?	*This is a topic that has been discussed at length previously. Whilst the recent media coverage may cause concern, I am confident that Detention and Escort Officers (DEO) are actively informing detainees of toilet pixelation, along with other areas such as the cell call buzzer, CCTV, etc when placing detainees in cells. All cells, in every DPP suite, also have stencils above the toilets*

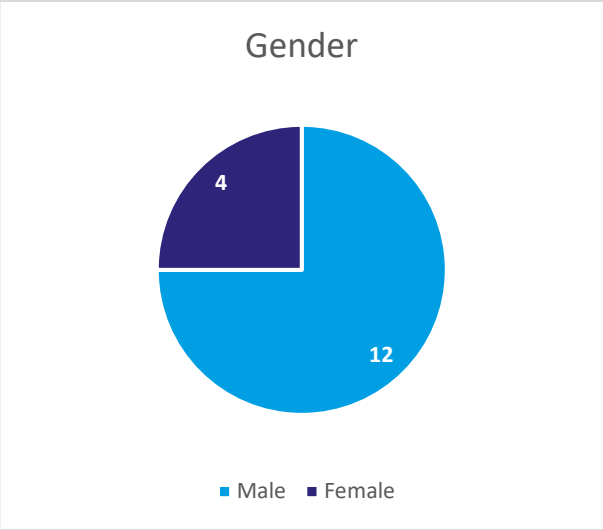
		advising detainees that the toilet area is pixelated. *However, to provide reassurance, Custody Services are continuing to explore a Detention Officer app which will be used on custody issue mobile data terminals to be used by DEOs. The MDT's and app will allow DEOs to complete actions on the move, removing delays to entries being made, and improving the accuracy and recording of information. This will include informing detainees of important information such as toilet pixelation and other cell functions. It will also include detainee welfare checks, cell checks, daily/weekly custody checks, etc. Custody Services will be meeting with Niche, who already have an app with this function, to assess the suitability of the app and ensure it covers all areas required. This will include key areas such as toilet pixelation.* *The introduction of this app will not only improve the quality and accuracy of information being recorded, but the entry templates on the app will act as prompts to ensure DEOs are informing detainees of ALL information required.*

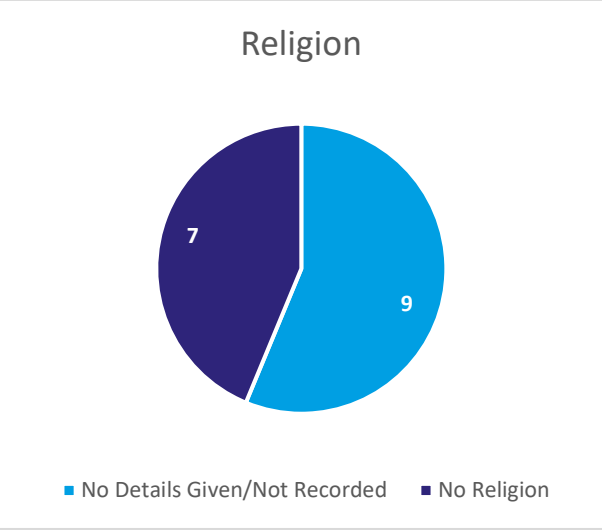
Annex- Custody Record Review Findings

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

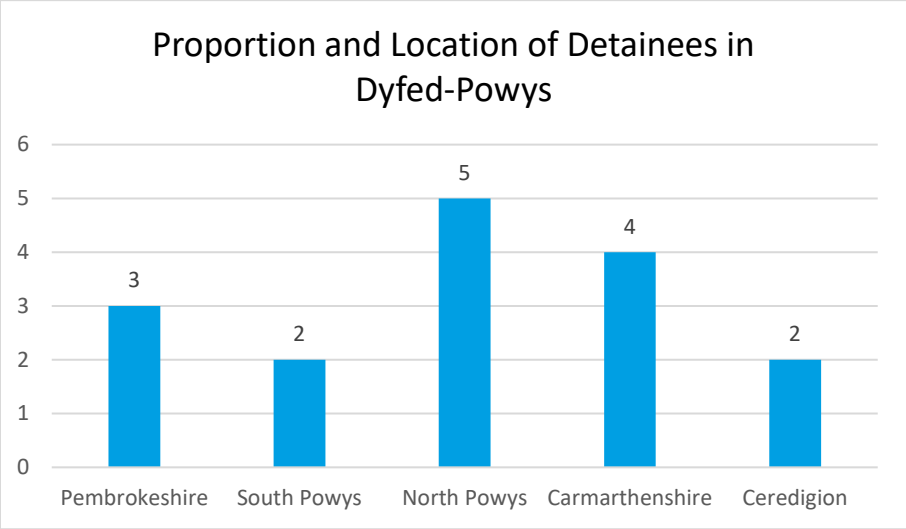






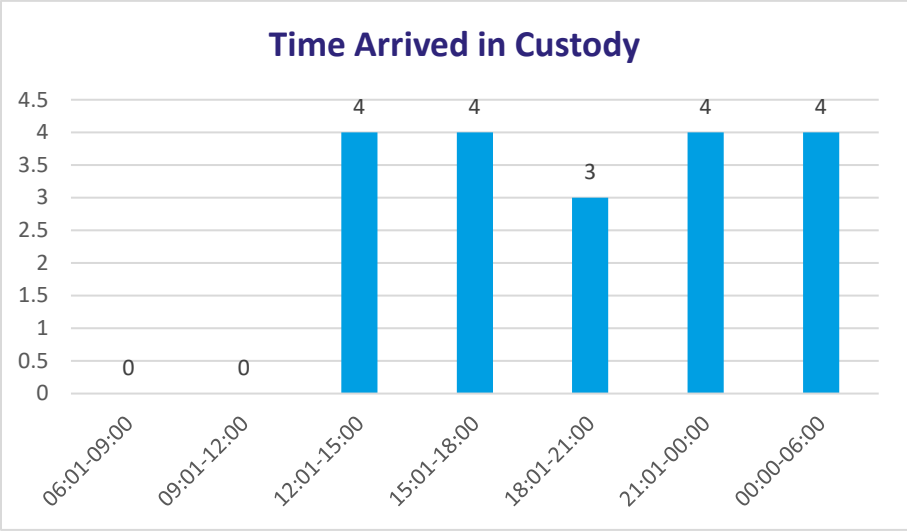
- The Ethnicity recorded for all detainees in this dip sample were 15 White British and 1 White North European.

Custody Suites



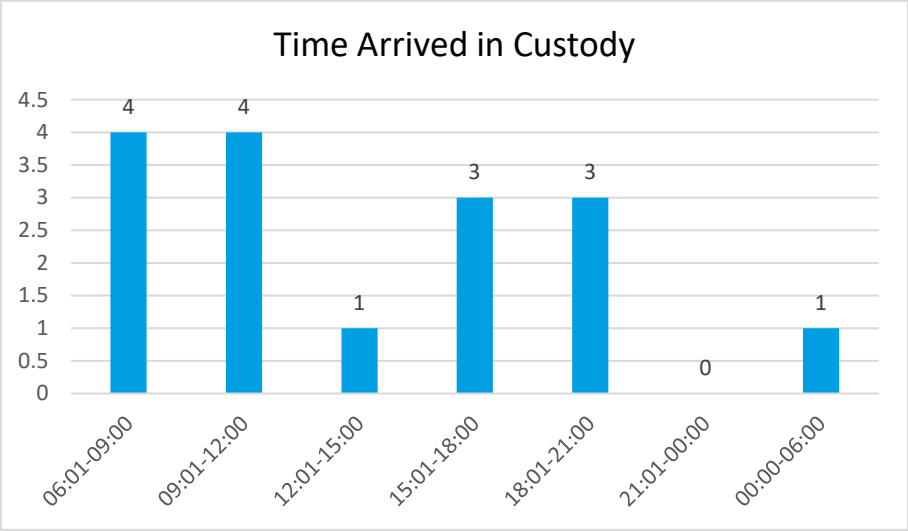
- Increased focus was placed on ensuring representation from all four custody regions within this scrutiny activity.
- Of the 30 cases prepared, each region contributed six custody records for Panel review.

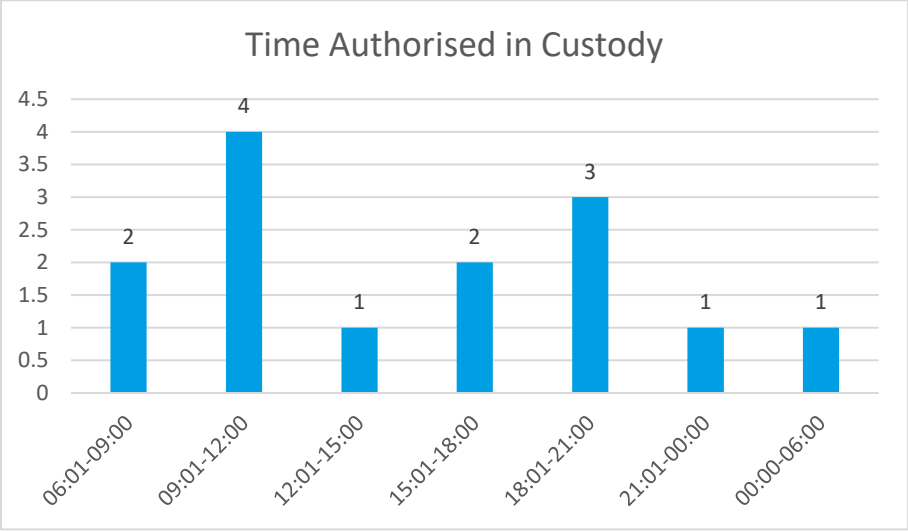
Time Arrived in Custody



Time Lapsed from Arrival to Detention Authorised

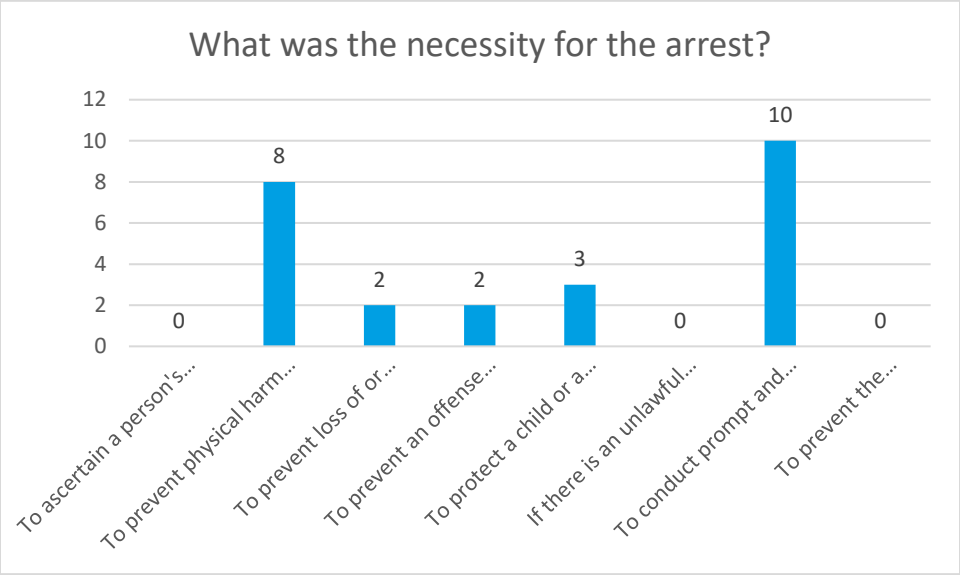
- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 35 minutes.
- The highest waiting time was 3 hours and 19 minutes.
- The fastest time for a detained person (DP) to have their detention authorised was 4 minutes.





Total Time in Detention

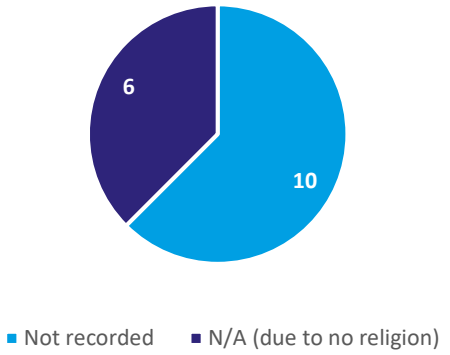
- The average time a detainee was held in custody was 9 hours. This has been affected by the Force's 12-hour PACE clock for processing children in custody.
- The longest time a DP was held in custody was 25 hours.
- In contrast, the shortest time a DP was held in custody was 2 hours and 16 minutes.



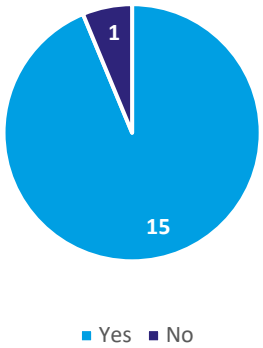
- The Panel were asked to ascertain the necessity for the arrest. An arrest is only lawful if it meets specific legal requirements under S24 of PACE.
- The list of necessities under PACE are:
- To ascertain a person's name or address
- To prevent physical harm to themselves or other
- To prevent loss 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* followed by *To prevent physical harm to themselves or other*.

Provisions in Custody

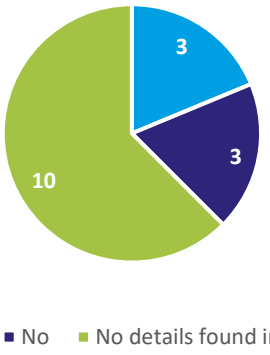
Were religious requirements catered for?



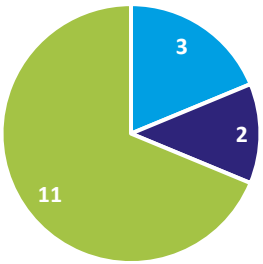
DP was asked about dietary requirements and allergies?



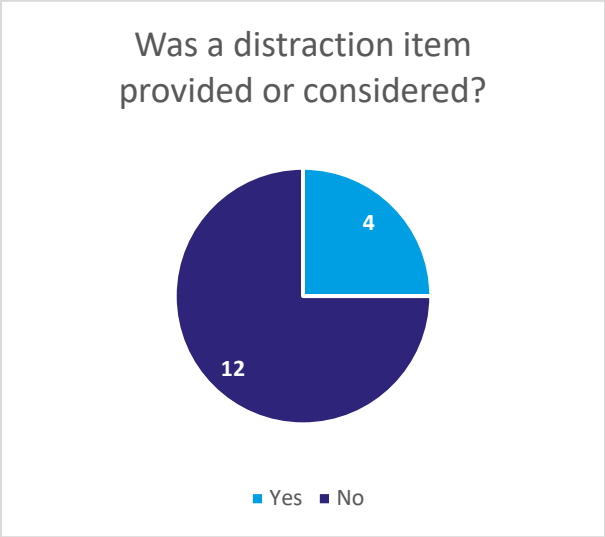
Was the DP instructed in the use of the cell call bell?



Was the DP instructed that the toilet is pixelated?



- The Panel specified that there were absences in the recording of religious needs, pixelation of the toilet and cell call button.
- However, all food and refreshments were deemed by the CISP to be offered to all DPs regularly.

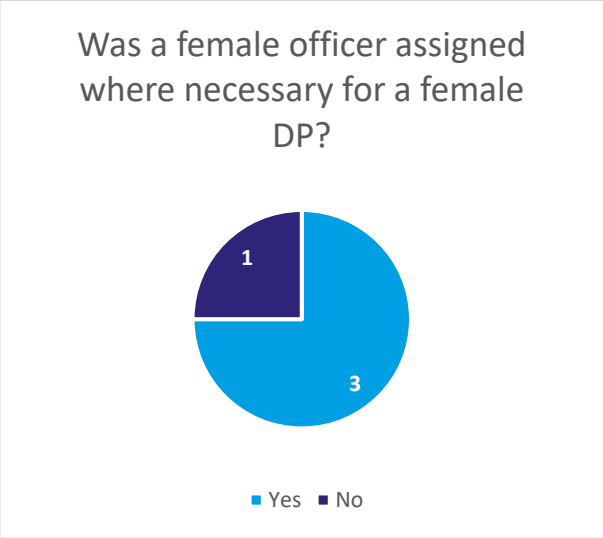


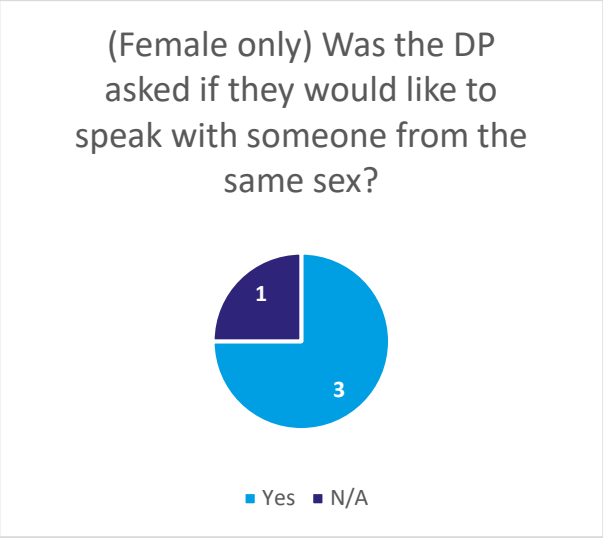
- A *distraction item* is a low-risk object provided to detainees to help reduce anxiety, agitation, or distress while in police custody. These items are particularly relevant for vulnerable detainees, including children, those with mental health needs, or individuals experiencing withdrawal or heightened 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 an absence of a risk assessment for all 4 records that provided a distraction item to a DP.

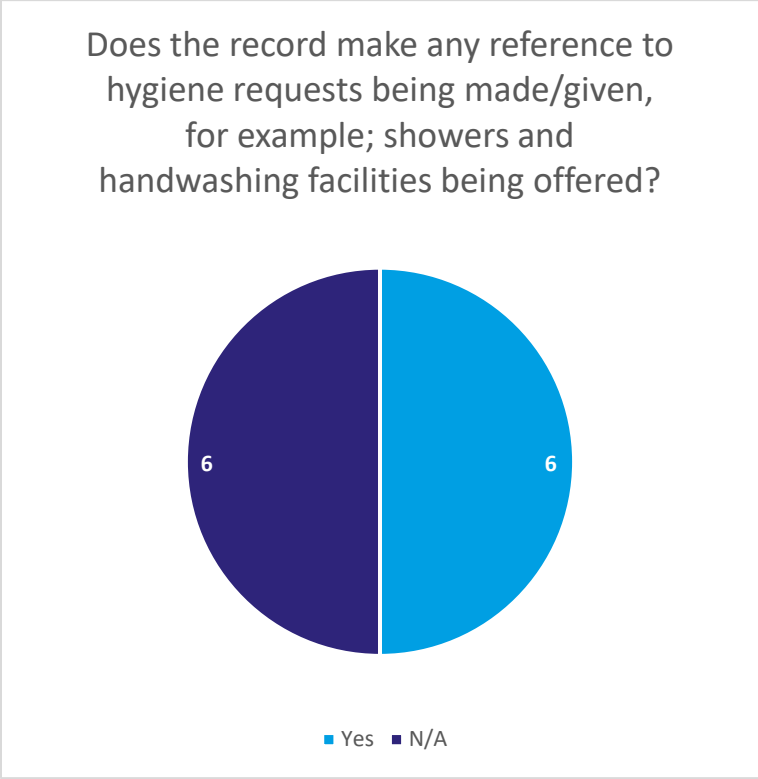
Female Detainees





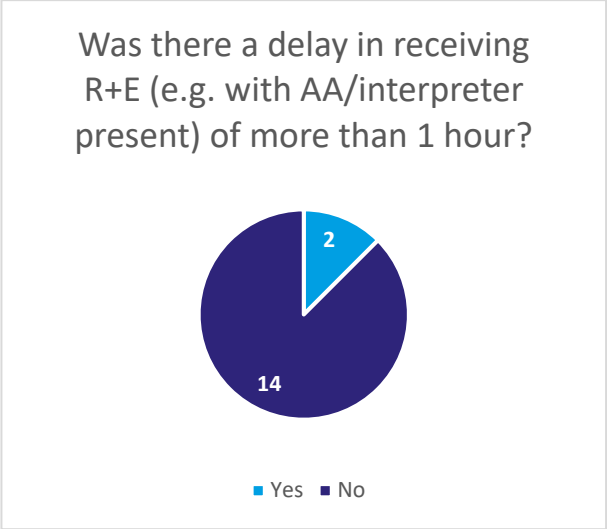
- A CISP member could not identify if the custody record had a female officer allocated.
- For the other custody records reviewed:
  - A female officer was allocated
  - The officer introduced themselves to the DP.
  - All DPs were offered menstrual products except one, due to their age.
  - All female DPs were offered hygiene facilities.

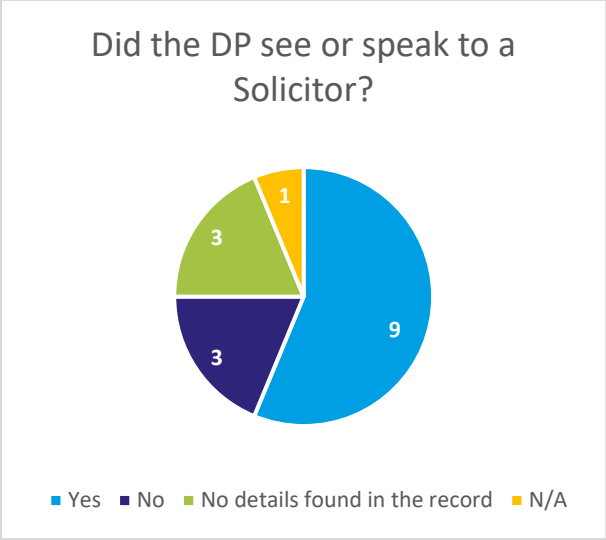
Hygiene



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

Rights and Entitlements





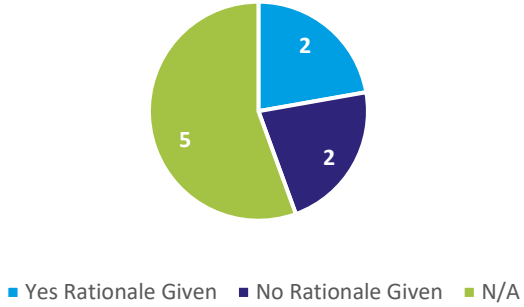
- All DPs were given their rights either at booking in stage or at a later stage during their detention.

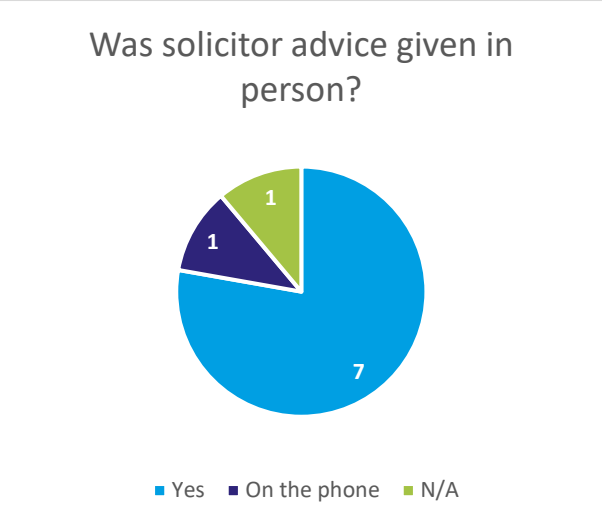
How long, after detention authorised, did the DP request a solicitor?

- The average time for a detainee took to request a solicitor was 29 minutes.
- In 12 of the 14 the records that requested a solicitor, the DP made the request for a solicitor within one hour.
- The longest period for a DP to request a solicitor was 1 hour and 22 minutes.

The length of time taken for police to contact a solicitor

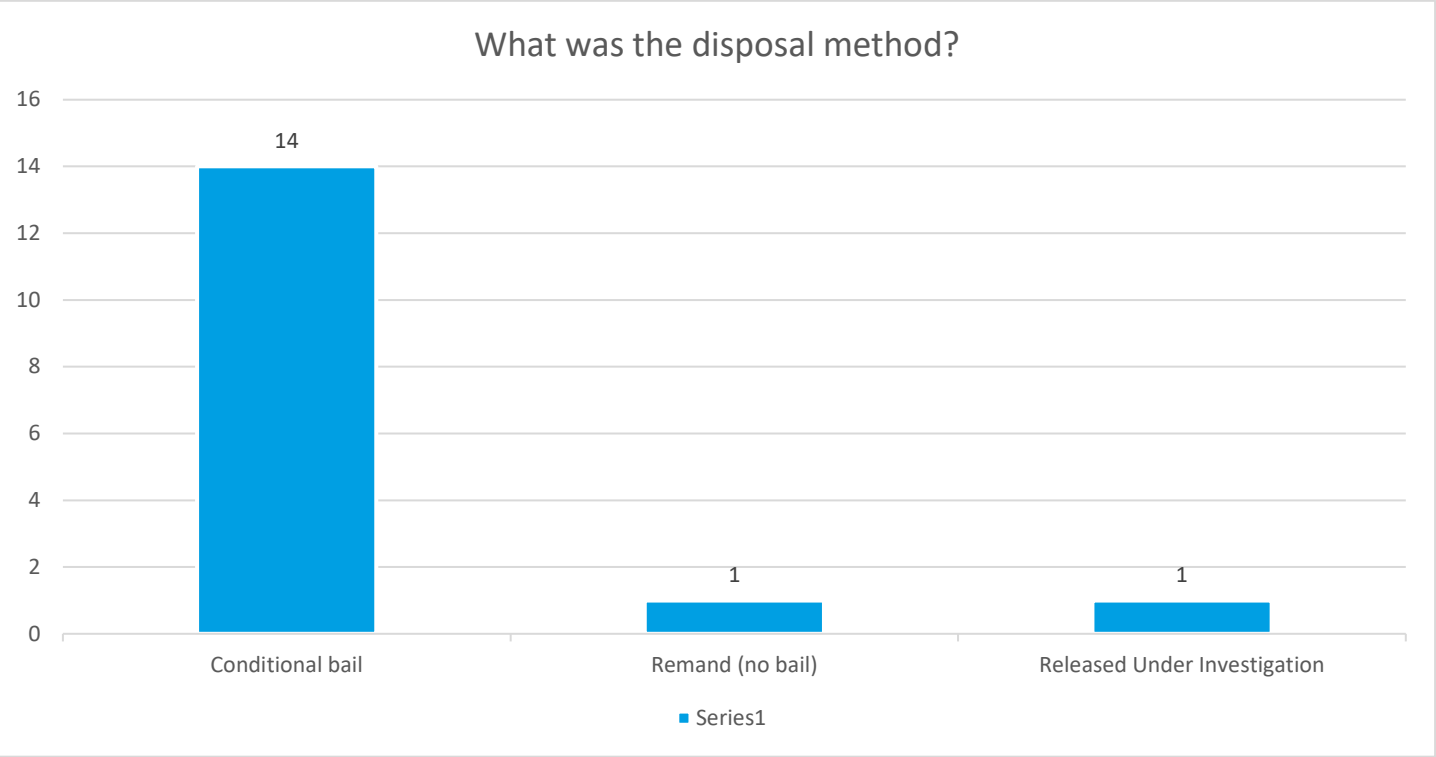
- The average time taken was 1 hours and 28 minutes for police to contact an on-duty solicitor.
- The longest period of time was 7 hours and 25 minutes.
- The shortest was 5 minutes.





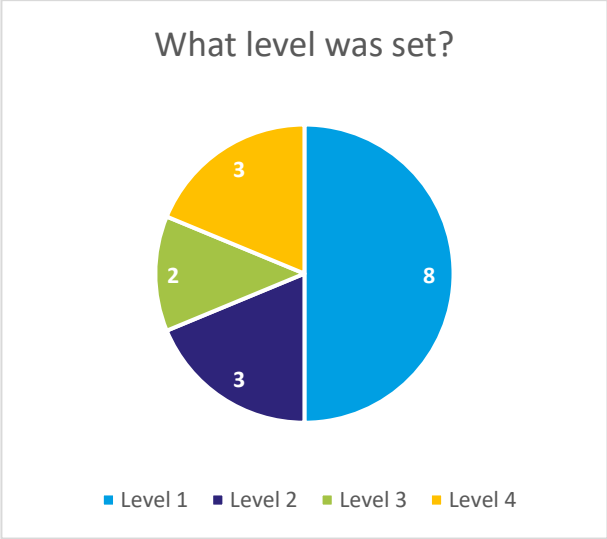
The length of time taken for solicitor to arrive from the point of being contacted

- The average time it took for a solicitor to arrive after being requested was 3 hours and 44 minutes.
- One CISP member found the record unclear to verify solicitor involvement.
- The CISP in the main had no concerns relating to vulnerable DP's having access to legal representation. There were delays, but these were justified.



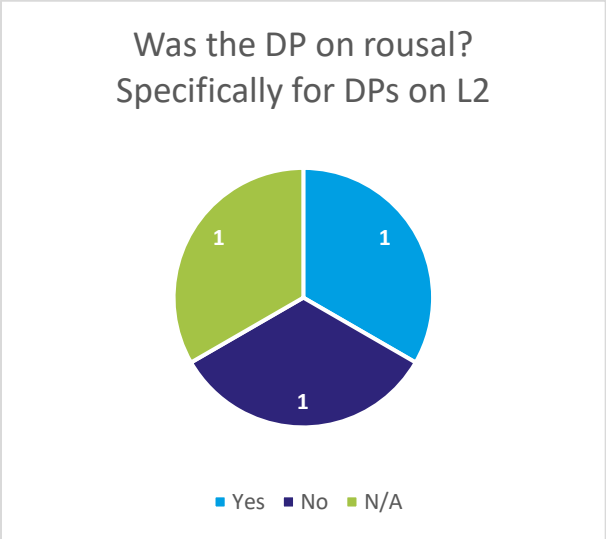
- The Panel were asked to note the disposal method to assess whether vulnerable detainees were detained proportionately to the necessity of arrest.
- 87% of disposal methods was for conditional bail which is the process that allows officers to attach conditions to bail which may support victims and/or witnesses, preservice evidence and mitigate further crime.

Observation Level

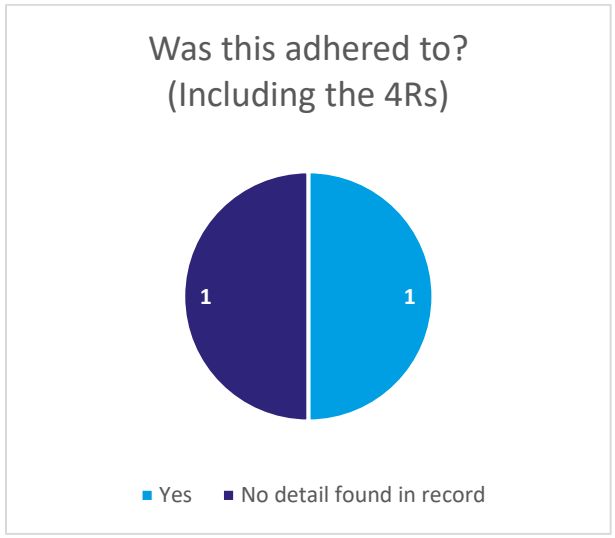


- All custody records reviewed had their observation level set and all were adhered to.
- The risk level is judged on 4 levels.
  - Level 1 General (at least once every hour)
  - Level 2 Intermittent (every 30 minutes)
  - Level 3 Constant (constant observation CCTV and accessible at all times)
  - Level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

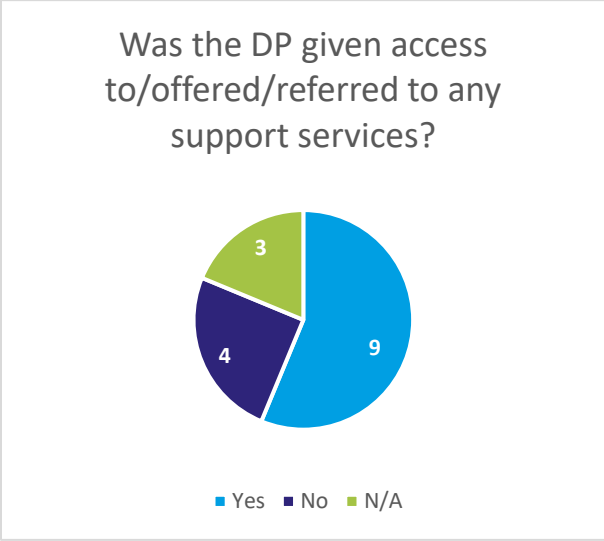
- The Panel recorded 95% confirmation that DPs risks were taken into account with only one record where the Panel member could not find the detail.



- One Panel member noted that the observational level 2 was not adhered to.
- Another Panel member put not applicable but it is not clear from the notes why this was the case.
- The CISP found evidence in the main that the observational levels were escalated and de-escalated well and good rationale was provided.


Was this adhered to?
(Including the 4Rs)
1
1
Yes
No detail found in record

Support Services

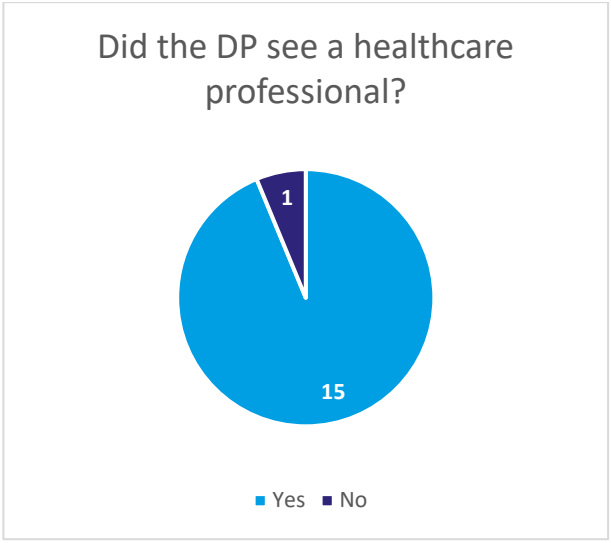


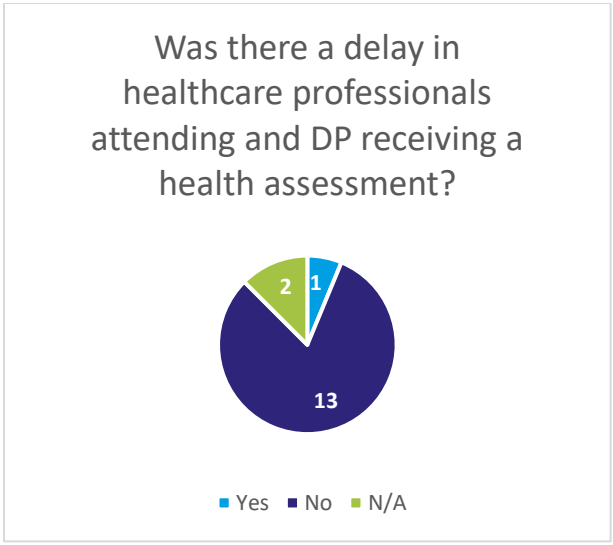
- 56% of DPs were offered support services in comparison to 25% who were not and 19% that this was not applicable.

- Panel members stressed the following support services to support DPs:
  1) MH services
  2) Social care
  3) Children and Adolescent Mental Health Service (CAHMS)
  4) Dyfed Drug and Alcohol Service (DDAS)

- CISP members noted on two occasions, support services were declined.

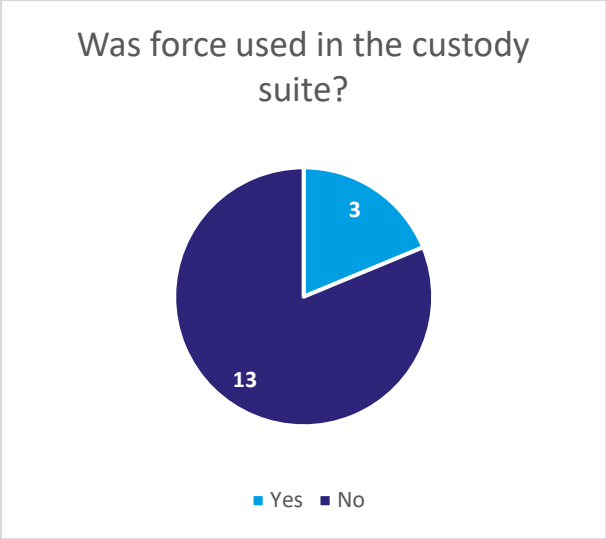
Healthcare Professional (HCP)





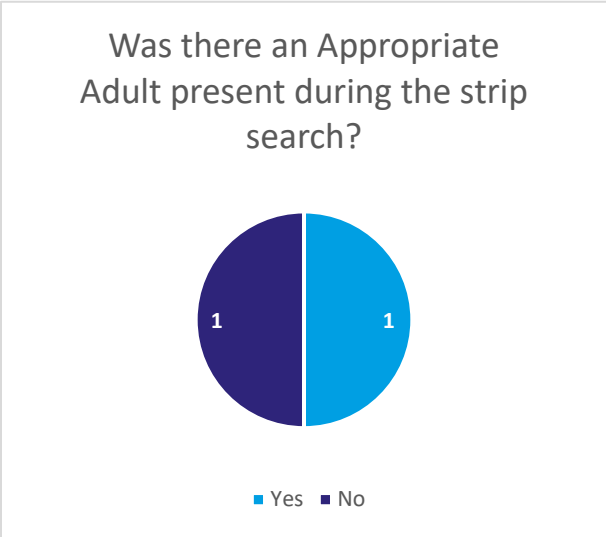
- The Panel noted the following observations in relation to HCP provision:
  1) Evidence of Health and Welfare needs were discussed in front of an AA.
  2) Evidence of caring and professional manner from staff, in some difficult circumstances.
  3) Good practice associated with identifying vulnerability, notifying AA and DP being assessed by HCP.
  4) Mental health and alcohol dependency concerns noted and dealt with accordingly with mediation and consultation with HCP.
  5) Good safeguarding measures in place to protect children entering custody with the focus to reduce the time they are in detention.

Use of Force

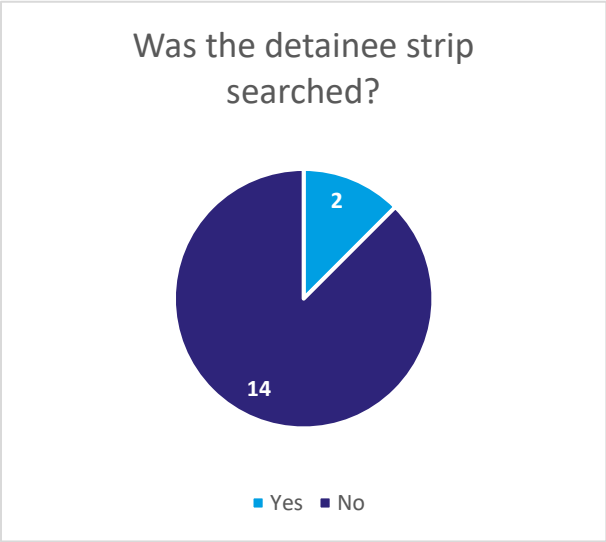


- In all three records reviewed, the tactic applied by custody in using force was applying handcuffs.
- In all three instances the CISP judged that the application was necessary and proportionate, and that the rationale was sufficient.
- No injuries were incurred neither to the DP nor the staff as a result.
- The CISP specified that:
  - The force used was proper and correct.
  - Procedures were followed and observation level adjusted accordingly.

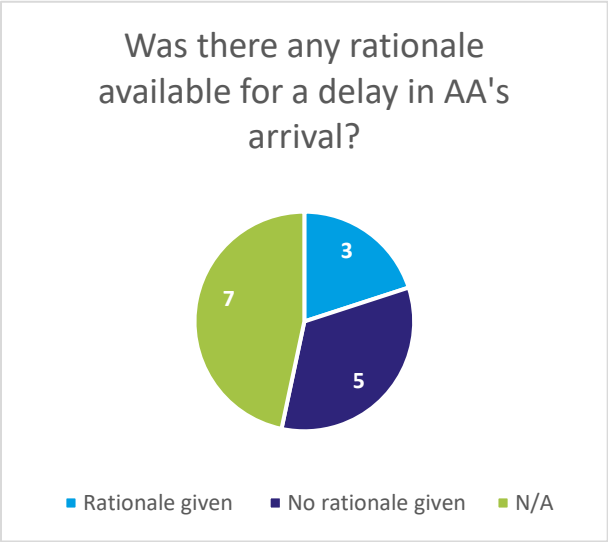
Strip Search



- The CISP advised that there was a good rationale associated with both strip searches that occurred.
- There was no Appropriate Adult (AA) present for one of the strip searches conducted as this was a Davies vs Merseyside- this is the exchange of the DP's clothing for custody clothing but not done with the purpose of searching on their person. This must be recorded as a strip search for ethical reasons.
- In neither instance could either CISP member identify whether CCTV was advised to the DP as being obscured or turned off during the search.

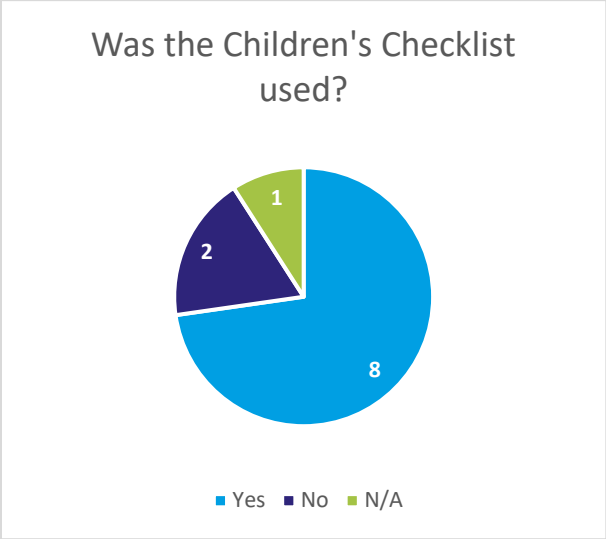


Mental Health (MH), Appropriate Adults (AA) & other Vulnerabilities



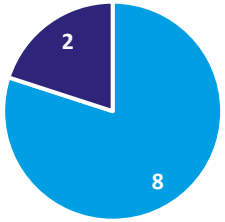
- In all instances, the CISP found evidence that the Force identified that an AA was necessary and, in all instances, the nominated person/AA was contacted.
- The average time for a detention officer to make contact with AA was 46 minutes, and the average time the DP first made contact with an AA was 1 hour and 26 minutes.
- The longest period was 4 hours and 52 minutes in contrast there were 3 records where this was done immediately.
- 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

Children in Custody

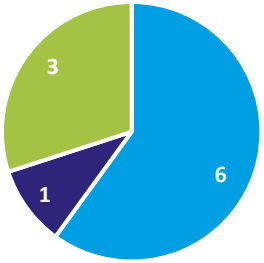


- It is suspected that from reviewing the results, the not applicable for the children's checklist was submitted in error.
- The average total time a child detainee was held in custody was 6 hours and 17 minutes.
- There was no instance where a child was detained overnight.
- The CISP specified that the process of expediting a child in custody appears to be making a positive impact in ensuring safeguarding of the child and reducing the time they are being detained in custody.
- There was one instance where Reachable Moments was not completed on the premise that there were no youth workers available.
- One record did not complete the Voice of the Child on the premise that the child was awaiting to see the HCP.

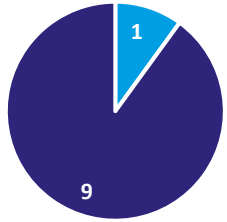
Has there been an Inspector's review within 1-2 hours of the child detained?



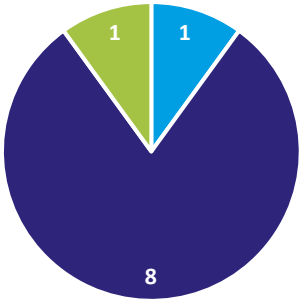
Has the 6 hour PACE review been completed?



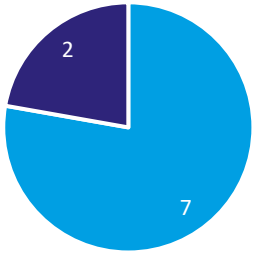
Has the third Inspector review taken place (12hour PACE clock for children)?



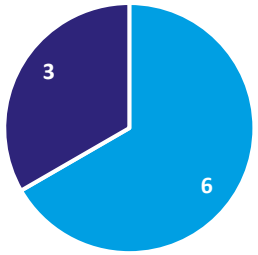
Was the child charged?



Was the Voice of the Child recorded?



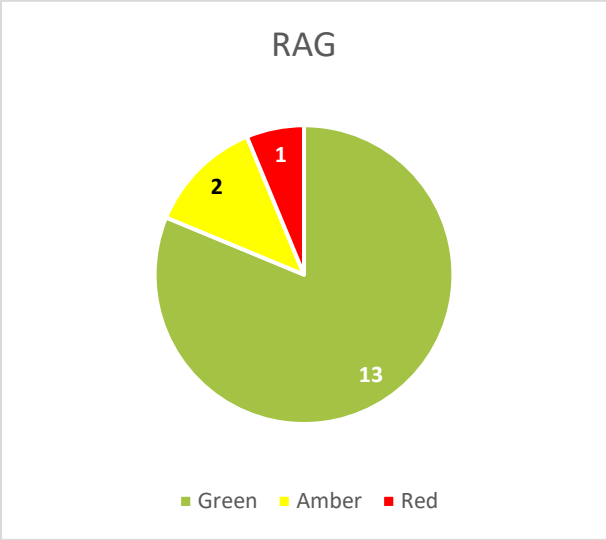
Has a reachable moments interview occurred?



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:

"There was a clear intention and plan to make the DP feel at ease and had mother the whole time. He was observed at 11 30. Apart from specifically using the child check list they have followed care and a quick clock for releasing on bail with mother fully involved."	*"There is a lot of information recording of behaviours shown by DP and that is good to see. Responsive to the levels of observation. Possibly because of that there appears to be missing information. I therefore feel important info is missing and rated Amber"*	*"No inspector reviews recorded. No sergeant (not custody) recorded."*
"Due to nature of arrest and age of DP. Dealt with professionally and handled with great care."	*"No records of Pixelation of toilet area, or Cell Call bell direction. No record of arrival time of Appropriate Adult."*	
"A difficult case handled sensitively with reasonable outcome."		
"Excellent use of the children in custody check list. It was clear and all aspects were covered. Very short time in custody and DP was well supported"		