



Report on an unannounced inspection visit to police
custody suites in

South Wales

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

11–22 April 2016



This inspection was carried out in partnership with the Care Quality Commission.

Glossary of terms

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Section 1. Introduction

This report is part of a programme of unannounced inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

The leadership and management of custody within South Wales Police were strong and there was a clear vision about what was required. The force had a coherent plan for custody, which was based firmly on making best use of resources while at the same time providing safe and decent conditions for detainees. There had been some significant improvements in the way that performance was managed, and this was closely linked to better information gathering. Managers were aware of the weaknesses that existed and appeared to be committed to addressing them.

Partnership working had begun to develop well and the force had introduced a number of positive collaborative initiatives. Joint work was being undertaken to address concerns about individuals detained under section 136 of the Mental Health Act being taken into custody, as well as children being detained in custody overnight. As a result, the number of vulnerable adults being detained was reducing. The positive impact was less clear in relation to children, however, and this remained an area of concern. In a small number of cases, police custody had been used as a place of safety for a child, which was unacceptable.

We were also concerned to discover that despite a recommendation at the previous inspection, until very recently the use of force had not been monitored. Although we did not discover any serious adverse findings, there had been no assurance that force was used safely and proportionately.

At a strategic level, there had been a welcome increase in focus on equality and diversity since the previous inspection. Staff we spoke to mostly demonstrated a good awareness about the needs of minority groups, although more needed to be done to address the distinctive needs of women and children. The relationships we observed between staff and detainees in the custody suites were consistently respectful.

Overall, the approach towards risk was proportionate, although overcautious in relation to the routine practice of removing cords and other personal items. Staff handovers were disjointed and this procedure needed to be streamlined.

We were concerned about the way that detainees were booked in and advised of the reasons for their arrest as this did not meet PACE requirements, and needed to be corrected immediately. The approach towards dealing with detainees' complaints was inconsistent and confusing, and as a result detainees did not have a reliable method of raising concerns.

One of the most significant changes since the previous inspection was the improvements made to the physical environment. All of the suites now were relatively modern. The conditions in which detainees were held were at least adequate for all detainees, and were good for those held at the two newest sites.

Staff did not receive adequate training on safeguarding, and relevant issues were not always identified or acted on. The appropriate adult scheme was not always responsive enough for children.

The provision of health care was generally good. Effective work had been carried out to address the difficulties associated with individuals detained under section 136.

There were some positive elements within pre-release planning, including a strong focus on welfare, but this was not always reflected in the records, which were poor.

Working relationships with the courts were sound and this generally resulted in detainees being dealt with promptly.

Overall, this was a positive inspection and significant progress had been made in key areas within custodial services. A certain standard for treatment and conditions in custody had been set by the force and this had helped to bring about improvements in the day-to-day living environment for detainees. Greater attention was also now being paid to the needs of minority groups, and, importantly, fewer vulnerable adults were being held in custody. Where weaknesses existed, such as the relatively high number of children still being held in custody and the lack of governance surrounding the use of force, action was being taken to address them. Based on our findings, we believe that there is a strong commitment within the force to sustain these types of improvement.

We noted that, of the 27 recommendations made in our previous report after our inspection of December 2011, eight recommendations had been achieved, eight had been partially achieved, nine had not been achieved and two were no longer relevant.

This report provides three recommendations to the force, and highlights 25 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

September 2016

Section 2. Background and key findings

- 2.1** This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.
- 2.2** The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*¹ about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.
- 2.3** On this inspection, we introduced the third version of *Expectations for Police Custody*. The new approach builds on learning from HM Inspectorate of Constabulary's thematic inspection of the welfare of vulnerable people in police custody and from the cumulative experience of our joint inspections of police custody to date. In particular, greater focus is placed on diversity, use of force, safeguarding and the treatment of children and vulnerable adults. We have also extended the range of our inspection to cover early contact and diversion, so we can obtain a more complete picture of the detainee's 'journey'. The format of the report has been redesigned to reflect the nature of these changes.
- 2.4** A documentary analysis of custody records was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.² The analysis focused on the legal rights and treatment and conditions of the detainee. A total sample of 153 records were analysed.

¹ <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

² 95% confidence interval with a sampling error of 7%.

- 2.5** This was the second inspection of South Wales Police, following up on our first inspection on 5–8 December 2011. During our 2016 inspection, the designated suites and cell capacity were as follows:

Custody suite	Number of cells
Cardiff Bay	60
Swansea	28
Merthyr Tydfil	42
Bridgend	42

Leadership, accountability and partnerships

- 2.6** There was effective governance and strong leadership from the chief officer group. This, combined with priorities set by the Police and Crime Commissioner (PCC), helped to provide clear direction for the custody service. A change programme was currently under way; this was designed to reduce costs, but also provide a more effective and efficient service.
- 2.7** The resources and staffing levels for custody were under review at the time of the inspection as part of a major change programme. Vacancies and sickness absence meant that the service was being delivered by insufficient staff. This was having an impact on the delivery of custody services (see also section on detainee care and PACE reviews).
- 2.8** Diverting children and people with mental health needs away from custody had been prioritised. This had resulted in a reduction in the number of people being brought into custody under section 136 of the Mental Health Act. Progress against a previous recommendation to transfer children to local authority accommodation, to avoid overnight detention, had been too slow and the number of children detained in custody overnight remained too high.
- 2.9** The force had strengthened its approach to performance management. It had recently introduced a method for capturing and reporting on performance. Performance information covered a range of relevant areas but there were some key gaps, for example, data on complaints, strip-searching and use of force. Inspectors were expected to disseminate performance information to their staff and it was also available on the intranet. The force was taking part in a pilot to monitor and learn from adverse incidents which had led to an increase in relevant learning being shared within the force.
- 2.10** There was a strong focus on equality and diversity at a strategic level, with a specific objective to meet diverse needs in custody in the joint equality action plan 2015–2018. The equality, diversity and human rights (EDHR) board provided effective governance in monitoring progress against the objectives set. Data collection had improved and was now being used to target priority areas. The EDHR board had driven the improvements in custody for individuals detained under section 136.
- 2.11** The force met the independent custody visitors (ICVs) regularly to look at key areas, and ICV members confirmed that their views and the scrutiny they provided were welcomed.

- 2.12** Despite a recommendation made at the previous inspection the force had only started monitoring the use of force since 1 April 2016. Before this, it had had no means of capturing relevant information, which meant that it was unable to demonstrate to the PCC, and the wider public, that force used had been proportionate or necessary.
- 2.13** Overall, quality assurance processes were not sufficiently robust. The required dip-sample of 40 cases a month was too small and there was little or no cross-referencing of cases with CCTV footage. There was limited assurance to show that detainees were dealt with properly and that their welfare needs were always met.
- 2.14** A range of effective partnership arrangements and schemes supported the diversion of vulnerable adults and children away from custody. Services provided by external contractors were monitored appropriately. The Women's Pathfinder project, the 18–25 triage initiative and the innovative Keep Safe Cymru card were all good examples of effective partnership working. The force was working with the Welsh Government to develop a mental health concordat for Wales, and work with partners at a strategic level was beginning to lead to improvements.

Pre-custody: first point of contact

- 2.15** There were good internal police systems for sharing information, and call handlers and dispatchers used them confidently. Relevant information, such as warning markers, were prioritised carefully and communicated efficiently to officers.
- 2.16** Police officers and staff received regular training that helped them to make assessments about individuals' risks and needs. Staff told us that they had also received training on the Mental Capacity Act 2005. However, with the exception of cases where the individual had obvious mental vulnerabilities, such as dementia, they were not fully aware of how to apply the principles of the Act. Officers were not always aware of whether an individual they were responding to was receiving any help from support services.
- 2.17** Police officers generally used the necessity test effectively. The impact of custody on vulnerable people was considered carefully and balanced alongside the safety and security of the public. Officers and staff demonstrated a good understanding of the various diversion schemes in the force, and used these well.

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

- 2.18** The custody staff we observed were friendly and respectful in their engagement with detainees. Staff we spoke to generally demonstrated a reasonable awareness of the range of vulnerabilities facing minority groups in custody. However, the practice we observed, or viewed in case audits, did not always reflect this, and there was little evidence to show that the distinctive needs of women and children were always paid sufficient attention.
- 2.19** Whiteboards in the rear office at Swansea were clearly visible to detainees standing at the booking-in desk, which meant that confidential information could be seen.
- 2.20** Detainees with disabilities could be accommodated suitably at the newer suites at Merthyr Tydfil and Bridgend, but records indicated that some of the individualised care provided was poor.

- 2.21** Risk assessments were thorough and completed well. Levels of observation were generally appropriate, justified and suitably amended as circumstances changed. The use of four-hour sobriety reviews for detainees who were intoxicated or unwilling to engage with the risk assessment process demonstrated effective ongoing risk assessment.
- 2.22** Anti-rip clothing was sometimes used for reasons which were not properly justified and some detainees remained in it for too long. Corded clothing and other items (such as wedding rings and shoes without laces) were removed routinely from detainees without considering the actual risk that each individual presented.
- 2.23** The management and control of cell keys was sometimes lax. Some staff attended cells without carrying anti-ligature knives, which was poor practice.
- 2.24** Staff shift handovers were disjointed, with information being exchanged separately between sergeants and between custody detention officers (DOs), with some staff receiving no handover at all.
- 2.25** At some of the suites, arresting officers shared the reasons and grounds for arrest with custody sergeants without the detainee being present, which was a breach of PACE.
- 2.26** Many custody sergeants were able to provide examples of instances when they had refused to give authority to detain, when there were insufficient grounds to do so. Alternatives to custody were available in the form of voluntary attendance, restorative justice, fixed penalty notices and street bail (see paragraph 5.25). Voluntary attendees had to be booked in within the custody suite environment, which was not a true diversion from custody.
- 2.27** Custody staff told us that most immigration detainees were moved on to alternative accommodation within 12–24 hours; however, we found evidence of longer delays – in a recent case, up to three days.
- 2.28** Custody staff were able to provide detainees with access to rights and entitlements notices in a range of different languages. An up-to-date version of the rights and entitlements material was available in Braille in all custody suites.
- 2.29** Custody staff provided us with mixed responses when asked how they would handle a complaint. Some said that it would depend on whether the complaint related to a custody matter or another issue. While some staff said that they would notify an inspector, others indicated that the detainee would be told to report their complaint at the front desk.

In the custody cell, safeguarding and health care

- 2.30** The newer custody suites were clean and well maintained. Swansea was by far the poorest facility. Daily cell checks were not conducted consistently in any of the suites. Showers did not always afford sufficient privacy and we were concerned by obvious ligature points in some designated washing areas, which we reported to local staff. Detainees were not always told how to use the cell call bell system. Staff at all sites were well versed in fire evacuation arrangements.
- 2.31** The governance of use of force was weak, and not all staff involved had received the annual officer safety/personal protection training. When force was used, it was not always recorded in custody records, and some staff had not submitted use of force forms. Tasers were rarely used in custody, and only ever in exceptional circumstances.

- 2.32** Many compliant detainees remained in handcuffs, sometimes for long periods, after their arrival in custody as officers did not have the discretion to remove handcuffs in custody. We saw some searches taking place while compliant detainees were handcuffed, which was uncomfortable for them.
- 2.33** Strip-searching was not carried out routinely. When it did occur, it was generally properly justified and authorised but strip-searches were not always conducted out of view of closed-circuit television (CCTV) cameras.
- 2.34** Detainees were not always given the opportunity to take showers or exercise. There was a shortage of replacement clothing in most of the custody suites, resulting in some detainees having to be issued with paper suits or anti-rip clothing instead, which was inappropriate. Replacement footwear was not issued routinely, and we saw detainees in all of the suites walking about in bare feet or socks.
- 2.35** Staff were not proactive in offering the limited stock of reading materials that was available, none of which was appropriate for children or for those who did not speak English.
- 2.36** The PACE reviews we observed were not always timely or conducted thoroughly. In our custody record analysis (CRA), over a third of first reviews had taken place either too early or too late. We saw no detainees being reminded that sleeping reviews had taken place.
- 2.37** Most custody staff we spoke to were aware of how to make a safeguarding referral.
- 2.38** There were some frailties in the appropriate adults (AA) scheme. Generally, support for vulnerable adults was readily accessible and responsive. However, AAs were not always requested and some vulnerable detainees were dealt with in the absence of an AA.
- 2.39** There were sometimes also long delays in organising AAs to attend for children. In most cases, they were only summoned in time for the interview, which meant they were unable to support the child or vulnerable adult throughout their period in custody. We were concerned to discover that in a small number of cases, because suitable accommodation could not be found, a police station had been used as a place of safety.
- 2.40** The quality of patient care was good. Health services had improved and detainees we spoke to were content with the provision.
- 2.41** Generally, clinical rooms were of a high standard, but there were some problems with infection control (wrong taps; no hand-washing guidance displayed). Facilities at Swansea were not fit for purpose as adequate levels of hygiene could not be maintained.
- 2.42** Response times by the ambulance service were also having an adverse impact on some detainees. The force had begun to monitor this and was seeking ways to address the problem.
- 2.43** Medication management was very good and opiate substitution therapy was available in custody. Although symptomatic relief of withdrawal from drugs and alcohol was offered, detainees did not have access to smoking cessation therapy, which was a significant weakness. Substance misuse services were well developed and effective.
- 2.44** The standard of mental health services was generally good but access to practitioners was not consistent between custody suites or throughout the day.
- 2.45** Before 1 April 2016, the use of police custody to detain individuals under section 136 had been falling, but was still too high. The use of police custody for individuals detained under

section 136 had since been prohibited (except for violent detainees), with encouraging initial results.

Release and transfer from custody

- 2.46** Information on many of the pre-release risk assessment records we reviewed was poor and we found a number that suggested that identified risk factors had not been addressed before release. However, risk assessments that we observed directly demonstrated that custody sergeants were properly focused on securing a safe release for detainees, including, where necessary, arranging police transport to take them home.
- 2.47** Custody staff told us that the local remand courts would normally accept detainees up to 4pm on weekdays, with some flexibility on occasions. However, staff at Swansea sometimes walked detainees across the road to the court in handcuffs, with no consideration for the detainee's privacy or public intrusion.

Areas of concern and recommendations

Area of concern

- 2.48** The force was not sufficiently effective within its strategic partnerships to ensure good outcomes for children. A particular area of concern was the lack of local authority accommodation provision for children who had been charged and refused bail, resulting in children being detained in police custody unnecessarily.

Recommendation

South Wales Police should engage with their counterparts in the local authority to instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells.

Area of concern

- 2.49** We saw many arresting officers discussing the reason and grounds for arrest with custody sergeants without the detainee being present. Sergeants did not always then attempt to confirm whether or not the detainee had fully understood the reason for their arrest.

Recommendation

Detainees should always be present when the arresting officer explains the reason and grounds for their arrest to the custody sergeant.

Area of concern

- 2.50** All aspects of the use of force lacked effective governance and oversight. The force did not record data on the use of force in custody effectively. Despite the availability of a new use of force form, not all staff submitted one following involvement in an incident involving the use of force. Some staff did not receive training every year or were out of date with training. Unapproved equipment was used to assist in the restraint of detainees.

Recommendation

South Wales Police should maintain effective management oversight of use of force incidents and trends. Incidents involving force should be quality assured and cross-referenced with closed-circuit television. All staff involved in incidents in which force is used should complete individual use of force forms. Staff should be adequately trained in a range of techniques that are appropriate for a custodial setting, at least every 12 months. Force should only be used at the lowest level and be commensurate with the threat posed, and only approved equipment should be used.

Section 3. Leadership, accountability and partnerships

Expected outcomes:

There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

- 3.1** The chief officer group demonstrated strong leadership in the delivery of custody services. There was a clear focus on keeping detainees safe, meeting legal requirements and dealing with detainees quickly. There were objectives to divert people away from custody, particularly vulnerable adults and children. This strategic focus was reflected at an operational level by a range of referral schemes concentrating on diverting detainees away from custody, and during the inspection, staff demonstrated a good awareness of these.
- 3.2** The management of custody services was effective. The assistant chief constable (ACC) was the strategic lead, supported by a superintendent of justice services and a chief inspector, who was head of custody services. At an operational level, the four custody suites were each managed by a designated inspector, supported by the local duty inspector. In addition, the Police and Crime Commissioner's office provided staff to assist with the delivery of specific areas of business – for example, work on initiatives to divert detainees with mental health problems.
- 3.3** The force had adopted national policies and guidelines for the delivery of custody services from the College of Policing professional practice for safer detention. Where needed, these were supported by South Wales Police guidance for specific areas of operation – for example, in relation to adverse incidents. This provided a good framework for guiding the delivery of custody services and ensuring compliance with nationally accepted standards.
- 3.4** The resources and staffing levels for custody were under review at the time of the inspection as part of a major change programme. This programme, although driven by the force's requirement to meet reduced budgets, aimed to deliver a more effective and efficient service. Work had been carried out to measure demand and establish the staffing levels required to deliver the service. The restructuring of the service had involved a reduction in the number of DOs from 112 to 85. Consultation was under way to introduce a more flexible approach to delivering the service by varying the number of staff and officers on each shift, to meet peaks in demand – for example, having more staff on duty during the weekend shifts.
- 3.5** However, the force acknowledged that it was not progressing with the change programme as quickly as it would wish as there were additional complications with transferring staff onto new contracts of employment. Senior officers recognised that this was affecting staff morale and resulting in a high staff turnover, and were seeking to address this. Recruitment was taking place for 12 DOs, although it was likely to be several months before new staff were in place. In the meantime, vacancies and sickness absence meant that the service was being delivered by insufficient staff. This was having an impact on the delivery of custody services (see also section on detainee care and PACE reviews).

- 3.6** Custody sergeants and other staff received training across a range of issues and there was regular refresher training. Recent training had included some input on safeguarding and vulnerabilities, specifically in relation to learning difficulties, transgender issues and children's custody needs. The training package for the current year was under development and, in response to identified areas of concern, would focus on the use of force, record keeping and welfare issues.
- 3.7** The arrangements for mandatory control and restraint training (known as 'officer safety training'), to ensure compliance with national guidelines on the use of force, were not robust. Compliance with the training was monitored, and information provided by the force indicated that 245 officers were out of the compliance period at the time of the inspection. There were plans to rectify this by the end of June 2016.
- 3.8** At a strategic level, the use of voluntary attendance (see paragraph 5.25), work by police schools liaison officers in dealing with incidents in schools, diversion schemes as part of antisocial behaviour interventions, and triage schemes for children, were all encouraged.
- 3.9** The force clearly recognised the importance of safeguarding children and vulnerable adults but there was a limited policy framework to guide this work. Referral arrangements were in place and used, but wider recognition of safeguarding issues was less clear. There had been some training on human trafficking, extortion and smuggling in the past, and some staff had also received generic safeguarding training.
- 3.10** The reduction in the number of detainees entering police custody under section 136 of the Mental Health Act³ was a clear priority for the force. Despite this, in the six months to the end of March 2016, 78 detainees had entered police custody under this legislation, which was still unacceptably high (see also section on partnerships).

Areas for improvement

- 3.11** **The force should ensure that all of its officers are fully compliant with the national training requirements for use of force.**
- 3.12** **The force should develop clear policies and procedures for safeguarding, supported by training, to ensure that these issues are always identified and acted on.**

Accountability

- 3.13** The force had strengthened its approach to performance management. It had recently introduced a performance management framework (Compstat). Performance information covered a range of areas, including custody throughput, booking-in times, bail, section 136 detentions, number of children detained and staff sickness. However, there were some key gaps – for example, data on complaints, strip-searching and use of force. In addition, in the case of booking-in times, the data could not be verified as accurate, relying on word of mouth rather than recorded information.

³ Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

- 3.14** There were meetings at different levels in the organisation to discuss performance, identify any concerns and, if needed, investigate further. Managers were expected to disseminate performance information to their staff and it was also available on the intranet. In addition to more formal reporting through Compstat, designated inspectors produced a daily report for the head of custody, including, for example, the number of children taken into custody, section 136 detentions and adverse incidents.
- 3.15** The force had only started monitoring the use of force since 1 April 2016. Before this, it had had no means of capturing relevant information, which meant that it was unable to demonstrate to the PCC, and the wider public, that force used had been proportionate or necessary (see also section on use of force).
- 3.16** Overall, quality assurance processes were not sufficiently robust. The required dip-sample of 40 cases a month was too small, this number was not always completed, and there was little or no cross-referencing of cases with CCTV footage. There was limited assurance to show that detainees were dealt with properly and that their welfare needs were always met.
- 3.17** There were satisfactory arrangements for recording adverse incidents or ‘near misses’ and learning from these. A log was maintained of all incidents, and each incident was reviewed by the inspectors and the head of custody. Any learning from incidents was appropriately extracted and circulated to all staff. The force was also taking part in a pilot study, sending reports of all incidents to the Professional Standards Department. As well as determining if any needed to be escalated to the Independent Police Complaints Commission, this also meant they shared them with other forces in Wales which encouraged wider learning. Adverse incidents were also discussed at the quarterly meetings of the ICVs (see below).
- 3.18** The chief constable chaired the equality, diversity and human rights (EDHR) board. This helped to ensure that the force was meeting its obligations under the Equality Act 2010 and the public sector equality duty, and provided a high level of scrutiny. There was a clear joint equality action plan and an annual monitoring report, both of which were published on the force website, but the monitoring report would have benefited from more commentary and analysis.
- 3.19** Meeting diverse needs in custody was a key objective in the joint equality action plan 2015–2018. Data collection had improved and informed the approach to prioritising the areas for improvement. For example, the EDHR board had been a key driver for the improvements in custody for section 136 detainees and children, and had been active in monitoring the various diversion schemes. Further work was under way to build up data around other areas, such as the use of force, strip-searching and the use of AAs (see also section on safeguarding). However, equality impact assessments had not informed the delivery of custody services. No impact assessments had been carried out in custody.
- 3.20** The ICVs provided effective scrutiny for the custody service. The force welcomed their involvement and met regularly with them, both regionally and at force level, to obtain their views on how custody was operating. They discussed any complaints, health and safety issues or adverse incidents that may have occurred, and obtained detainee views as expressed to the ICVs.

Area for improvement

- 3.21** **Dip-sampling of custody records should be increased to around 10% of the throughput of custody, to allow for a representative and meaningful sample and to facilitate organisational learning.**

Partnerships

- 3.22** There were a range of partnership arrangements and schemes that supported the diversion of vulnerable adults and children away from custody. The Women's Pathfinder project brought together the police, probation services, health services, local authorities and the voluntary sector to offer help and support to divert women away from custody and the broader criminal justice system. Although yet to be formally evaluated, at the time of the inspection the project had helped over 300 women, with a reported reoffending rate of 7%. Partnership working was also supporting the diversion of young people aged 18–25, through the 18–25 triage initiative. This was based on restorative justice and community resolution, to avoid the criminalisation of young people, and aimed to provide support to prevent and minimise reoffending. Similar schemes operated with youth offending teams, which offered support to divert children from entering the criminal justice system. The force also operated the Keep Safe Cymru scheme with partner agencies, whereby vulnerable individuals (with learning disabilities, dementia or mental health issues) were given the opportunity to provide information about their vulnerabilities to the force, and to carry a card which alerted the police to this information if the person came to their attention (see also paragraph 4.2).
- 3.23** Services provided by external contractors were monitored appropriately. There was a contract management group, chaired by officers from the PCC's office, to manage the new contract with Dyfodol, which was a consortium of organisations delivering substance misuse and a range of other diversion services. A criminal justice and mental health planning board, chaired by the ACC and a representative from the health services team, considered information about offender management issues and substance misuse. This was helping to ensure that outcomes for detainees in relation to their health care and any support needed in future to divert them from custody were adequately monitored.
- 3.24** The force was working with the Welsh Government to develop a mental health concordat for Wales, and work with partners at a strategic level was beginning to lead to improvements (see also paragraph 6.58). Although the number of detainees entering police custody under section 136 of the Mental Health Act was reducing, it was still unacceptably high (see also paragraph 3.10). The force's chief officer team was working with health services and other partners to improve the approach to dealing with people with mental health problems, solely in relation to those detained under section 136. This had involved agreeing roles and responsibilities, practical arrangements to avoid detention in the custody suite, and an escalation process. Agreement had been reached that, unless a person was displaying significant levels of violence, they would not be taken into police custody as a place of safety. These arrangements were not yet embedded and people with mental health problems were still entering custody rather than being taken to a health care-based place of safety (see also section on mental health). Although more people with mental health problems were being diverted away from custody, police officers were still spending large amounts of time with detainees waiting to be transported to hospital or remaining with them while at the hospital, which was poor use of police resources. The force had started to monitor this, to inform partnership discussions on how to address these concerns.
- 3.25** There was some joint working with partners around the provision of alternative accommodation for children who had been charged and refused bail, to prevent them from remaining in custody overnight. Training had been provided to increase the understanding between partners about their respective responsibilities for transferring children to more appropriate accommodation; an escalation process had been introduced; and working relationships with the main provider of accommodation had been established. Data on the children held in custody overnight were closely monitored by senior officers. Cases where alternative accommodation had not been provided were reported to the force commanders in each area (basic command unit; BCU), and subsequently to the local safeguarding children board. However, the number of children detained in custody overnight remained too high;

data provided by the force showed that in the previous year, alternative accommodation had been provided for only 14 children out of the 60 for whom it had been required (see also paragraph 6.29 and area of concern 2.48)

- 3.26** There were various arrangements for monitoring the outcomes of joint working with partners. These included: governance through a board and steering groups with police and probation representatives for integrated offender management work, particularly in relation to substance misuse and higher-risk offenders; some joint performance monitoring through area planning boards under the umbrella of the health services harm reduction meetings; and a Women's Pathfinder Board (see above), made up of partners with responsibility for delivering the scheme. However, it was not always clear how outcomes were identified when delivering shared objectives, and how these fed back into custody services.

Section 4. Pre-custody: first point of contact

Expected outcomes:

Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

- 4.1 The public service centre (PSC) was the call centre responding to all emergency and non-emergency calls to the police in South Wales. It was separated into two distinct operational areas. The call takers answered the 999 emergency calls and 101 non-emergency calls; assessed the level of threat, risk and harm; graded them for an immediate or non-immediate response and then passed all the necessary information to the call dispatchers. The call dispatchers were accountable for sending out the most appropriate response officers, depending on the grading of the call and area of the incident. Staff in the PSC worked effectively together and there was good oversight and support by supervisors. There were regular training events for PSC staff; recent training events had included topics such as honour-based violence and child sexual exploitation, and staff had also received some training in safeguarding and vulnerability.
- 4.2 Call handlers and dispatchers had good access to police information systems, particularly warning markers and information about any relevant vulnerability or the support needs of the caller or potential detainee. They were skilled at obtaining as much information from callers as necessary for grading the call and supplying the response officers with immediate relevant information. Some of the markers on the custody computer system (Niche) identified whether children were on the child protection register or were at risk, anyone subject to public protection arrangements, and those with substance misuse concerns. There was also a Keep Safe Cymru (see paragraph 3.22) marker, which automatically highlighted those who had signed up to the scheme, along with their specific needs and information on how they could best be communicated with and supported. Access to all of this information allowed police response officers to make informed decisions about the approach they would take at an incident, and informed their decision making. Police response officers we spoke to said that the information they received was relevant and that they used it to inform their assessment at an incident.
- 4.3 Multi-agency information was not readily available outside of office working hours to help call handlers to determine the level of risk or to assist response officers attending the incidents, and there were no representatives from partner agencies based in the PSC. Although information was shared between the police and partner agencies, and warning markers sometimes flagged up the involvement of other agencies, in such situations further information needed to be gathered from the latter, and this was not always possible outside normal working hours. This meant that response officers were not always aware of whether an individual they were responding to was receiving any help from support services.
- 4.4 Police officers and other staff received regular training that enabled them to make assessments about individuals' risks and needs. Police officers told us that they had received training on the Mental Capacity Act 2005. However, with the exception of cases where the individual had obvious mental vulnerabilities, such as dementia, they were not fully aware of how to apply the principles of the Act.
- 4.5 Police officers understood how to apply the necessity test and used it effectively. Officers told us that they considered the impact of custody on vulnerable people, including children, alongside the safety and security of the individual and the public. They demonstrated a good understanding of the alternatives to custody and provided examples of when they had used

these – particularly voluntary attendance and, more recently, restorative justice community resolution (see also paragraph 5.25). Data supplied by the force showed that voluntary attendance had increased by 67% over the previous three years.

- 4.6** The force was encouraging officers to detain vulnerable people and children only when necessary, but this did not always happen in practice. Officers did not have immediate access to mental health professionals to assist them in making decisions about how to deal effectively with detainees in need of mental health care. Some detainees presenting with obvious mental health needs were taken straight to hospital. Officers told us that their vehicles were unsuitable for transporting mentally vulnerable detainees to hospital and that this caused difficulties because they were often unable to secure assistance from the ambulance service for this purpose.
- 4.7** During the inspection, we observed some vulnerable people being brought into police custody, some of whom were visibly unwell and later received mental health interventions in police custody, which was inappropriate.
- 4.8** Some of the police officers we spoke to in the focus groups we held did not regard all children as vulnerable, which was concerning. Officers told us that they would determine whether a child who had committed an offence was vulnerable, depending on the prevailing circumstances. However, they were all aware of the procedures for alerting children's services and the public protection unit to any child who was at risk of harm.

Area for improvement

- 4.9 All staff should be trained in the Mental Capacity Act 2005 to enable them to respond effectively to individuals who might be mentally vulnerable.**

Section 5. In the custody suite: booking in, individual needs and legal rights

Expected outcomes:

Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

- 5.1** The custody staff we observed dealt with detainees in a constructive and professional way. Although Cardiff Bay custody suite had privacy screens between each of the booking-in desks, which afforded some privacy, detainees could be overheard when the suite was busy. At Swansea, two whiteboards containing detainees' personal details, sited in a rear office, were clearly visible to any detainee being booked in, which also compromised privacy.
- 5.2** The individual needs of detainees were not always fully met. There were not always female staff working in custody, so detained women were not always given the opportunity to speak to a female member of staff. Women were not routinely offered sanitary products or asked if they were pregnant. They were encouraged to complete a pre-release questionnaire about their care while in custody, but we saw few take up this opportunity and we were unsure what the force did with this information or if any improvements had been made as a result. Custody staff did not ask detainees about caring responsibilities so that alternative arrangements could be made but instead relied on detainees to raise such matters themselves.
- 5.3** Custody staff described variable experiences of training in equality and diversity. Those we spoke to had a reasonable awareness of a range of vulnerabilities facing minority groups in custody, but women and children were generally not deemed vulnerable by virtue of their gender or age, respectively. Based on our observations and the results of our case audits, we were not assured that staff had a full enough understanding about the variety of individual needs that detainees from minority groups presented (see also section on safeguarding).
- 5.4** Accessible toilet and shower facilities were available at Bridgend, Cardiff Bay and Merthyr Tydfil. The cells in these suites could accommodate wheelchairs. At the newer suites at Bridgend and Merthyr Tydfil, there were some lowered sinks and cell call bells, and the latter were sited next to the toilet. Many benches in cells were very low, particularly in Swansea. Rights and entitlements leaflets were available in Braille in all suites. During the inspection and in our case audits, we came across some poor individual care for detainees with disabilities. For example, the hearing aid of a 75-year-old man was removed, and a double amputee detainee using a wheelchair was located in a cell with a very low bench and struggled to get himself out of his wheelchair and onto and off the bench. Other than staff sometimes requesting an AA or mental health assessment for a detainee, there was little understanding or attention paid to the individual needs of detainees with learning disabilities/difficulties or mental health issues. However, we saw one good example of work in this area at Merthyr Tydfil, where a young adult with mental health issues was allowed to have a visit with his mother in a closed visits room.
- 5.5** Staff at Cardiff Bay told us that they were accustomed to dealing with transgender detainees. At other suites, there was considerable confusion about the treatment of such detainees and

we were not assured that staff would respect their requests, particularly regarding how they would be searched.

- 5.6** All custody suites had good stocks of religious books and items to support the main faiths.
- 5.7** Arrangements for dealing with foreign national detainees were reasonable. They were offered the opportunity to speak with their embassy or consulate. Translated documents were available (see also section on communication).

Areas for improvement

- 5.8** **Staff should be trained to recognise and provide for the individual needs of detainees, particularly children, women, detainees with disabilities and those who are transgender.**
- 5.9** **Custody staff should ask all detainees if they have any obligations as carers or are being cared for by others, and whether they need help to address these.**

Risk assessments

- 5.10** In most cases we observed, detainees were booked in promptly. However, in our case audits we found evidence of some detainees at Cardiff Bay having to wait between 40 minutes and just over 80 minutes to be booked in, which was excessive. In our CRA of 153 records, the average waiting time was 11 minutes, which was lower than the average figure of 18 minutes (from April 2015 to March 2016) supplied to us by the force.
- 5.11** Custody staff interacted well with detainees when completing risk assessments, and these were generally dynamic, thorough and appropriately focused. Custody staff paid particular attention to detainees' mental and physical health needs and asked probing supplementary questions to enhance the assessment. In some cases, DOs, rather than custody sergeants, completed the risk assessment with detainees, but sergeants supervised the process appropriately and were then responsible for completing care plans. In addition to the initial interview, staff took account of other sources of information during the risk assessment process, including markers on the police national computer and local intelligence systems. The custody records we reviewed highlighted that custody sergeants were proactive at placing warning markers in the custody records of vulnerable individuals, providing a helpful narrative of the risks that the individual presented.
- 5.12** The levels of observation that detainees were placed on were generally suitable. They were reviewed regularly by staff, changed appropriately and mostly complied with. In addition, sergeants used four-hour 'sobriety review' markers on Niche (see paragraph 4.2), to remind them to visit detainees who were intoxicated or unwilling to engage with the risk assessment process when they arrived in custody, which demonstrated ongoing risk assessment.
- 5.13** Anti-rip clothing was sometimes used with no recorded rationale. In some suites, we were told that detainees could be automatically placed in anti-rip clothing if they were uncooperative or inebriated, which was disproportionate. Some detainees who were placed in anti-rip clothing did not have their clothing returned until their release/transfer, even when their level of risk had reduced, which was undignified. We saw one detainee being transferred from a neighbouring force in anti-rip clothing; custody staff suggested that he may have been in this clothing as he 'had the potential to be violent', but no consideration was given to returning his clothing to him after the booking-in process, when he was deemed to be low risk.

- 5.14** The routine removal of corded clothing, wedding rings, hearing aids and footwear, even when there were no shoelaces or other ligature risks, was disproportionate, particularly when detainees were assessed as low risk (see also paragraph 5.4).
- 5.15** Staff were aware of how to rouse detainees when the level of observation required it, and did this well, engaging in varying degrees of contact and communication. However, the outcome of these checks was poorly recorded and did not always reflect the interaction or the degree to which the detainee should have been roused.
- 5.16** Management and control of cell keys was lax, especially during busy times. Operational officers, rather than trained detention staff, had access to keys, and collected and returned detainees to their cells, which was inappropriate.
- 5.17** All DOs that we saw, apart from two that we spoke to at Cardiff Bay, carried personal-issue anti-ligature knives. Most custody sergeants did not carry these, stating that they had not been issued with them. At Cardiff Bay, anti-ligature knives were attached to the cell keys but this was not the case elsewhere.
- 5.18** Staff shift handovers did not include all staff, and we saw sergeants and DOs handing over individually to their incoming peers, rather than as one team. We also observed one handover taking place alongside a detainee being booked in, which compromised privacy. At Cardiff Bay, staff who were not allocated to the cells in use at that particular time did not receive a handover, despite the fact they also had contact with the detainees in custody as they were responsible for fingerprinting and photographing them. The content of the handovers focused appropriately on risk, detainee welfare and case progression. Custody sergeants and DOs generally visited all detainees after the handover, to engage with and check them.

Areas for improvement

- 5.19** **Anti-rip proof clothing should only be used in exceptional circumstances and as a last resort, to protect the detainee from harm. There should be a recorded rationale, based on a risk assessment, and the detainee's own clothes should be returned to them at the earliest opportunity.**
- 5.20** **Removal of detainees' clothing, footwear and other items should be subject to individual risk assessment.**
- 5.21** **Rousing checks should be recorded and include full details, including the detainee's condition.**
- 5.22** **All custody staff should carry anti-ligature knives in the custody suites at all times.**
- 5.23** **All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded.** (Repeated recommendation 4.19)

Individual legal rights

- 5.24** In many cases, across all the custody suites, we saw arresting officers discussing the reasons for arrest with custody sergeants without the detainee being present. Custody sergeants used this information to open a custody record for the detainee. In some cases, the custody

sergeant then simply asked the detainee if they knew why they had been arrested, before authorising detention. They did not always attempt to confirm whether the detainee had understood the full reason for arrest before continuing with the booking-in process, which was a breach of PACE (see area of concern 2.49).

- 5.25** Many custody sergeants were able to provide examples of instances when they had refused to authorise detention, when there were insufficient grounds to do so. Alternatives to custody were available in the form of voluntary attendance,⁴ restorative justice,⁵ fixed penalty notices and street bail.⁶ In our case audits, we found evidence of street bail being used appropriately in the case of a woman who was 36 weeks pregnant; an arrangement was made for her to attend the custody suite at a mutually convenient time.
- 5.26** The management of voluntary attendees was a protracted process as these interviews could only take place using recording facilities within the four custody suites. Voluntary attendees had to be booked in by custody staff on Niche (see paragraph 4.2), and a risk assessment completed before the interview could take place. Unnecessary delays sometimes occurred while the attendee waited to be booked in alongside detainees, which was contrary to the aim of diverting individuals from custody.
- 5.27** Custody sergeants were aware of the need to keep detention to a minimum and were clear about their obligation to progress cases quickly. We were told that delays sometimes occurred – for example, when there were low staffing levels in the ‘hub’ teams (responsible for interviewing detainees in custody) or when waiting for Crown Prosecution Service decisions – but there were no adverse delays during the inspection. Data supplied by the force showed that the average length of detention pre-charge for the year ending March 2016 was nine hours 22 minutes, which was similar to the average figure in our Custody Record Analysis (CRA) of eight hours 56 minutes.
- 5.28** Custody staff reported a good relationship with Home Office immigration enforcement officers, one of whom was based at Bridgend. We were told that immigration detainees who were to be transferred to immigration removal centres were usually moved on within 12–24 hours, although some had experienced longer delays. We were told that, in the previous week, three detainees had been held in custody for almost three days. Data supplied by the force indicated that the overall average detention time for immigration detainees waiting for transfer in the year ending March 2016 was 19 hours 25 minutes.
- 5.29** During booking-in, custody sergeants and DOs advised detainees of their three main rights,⁷ and in most cases routinely offered them a written notice setting out their rights and entitlements, although this was rarely accepted.
- 5.30** At Cardiff Bay, we saw the mother of a 16-year-old boy attend to act as his AA. In the boy’s presence, a DO told her about her son’s earlier responses on being advised of his three main rights during booking-in and was asked if she agreed with them. She was not offered a copy of the rights and entitlements or the PACE codes of practice and the boy was not re-read his rights and entitlements in her presence; we were told that this was common practice. There

⁴ Usually for lesser offences, where the suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for arrest and subsequent detention.

⁵ Restorative justice is a process whereby some lesser criminal cases can be resolved at the time of the offence through an agreement between the offender and victim.

⁶ Street bail under Section 4 of the Criminal Justice Act 2003 enables a person arrested for an offence to be released on bail by a police constable on condition that they attend a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.

⁷ Three main rights – the right to have someone informed of their arrest; the right to consult a solicitor and access free independent legal advice and the right to consult the PACE codes of practice.

were insufficient copies of the up-to-date PACE code C available at all suites and we did not see these routinely being offered or given to detainees to read.

- 5.31** All detainees were offered free legal representation; there were posters informing them of this right in all the suites but only in English and Welsh. If they declined, they were told that they could change their mind at any time, but they were not always asked why they did not wish to seek legal advice, and their reason for refusing was not always noted on the custody record. Those wishing to speak to legal advisers were able to do so over the telephone, via the intercom in the privacy of their cell, or face-to-face in suitable consultation and interview rooms. It was the responsibility of interviewing officers to obtain a copy of the custody record front sheet for legal advisers, and these could be provided in Welsh if required.
- 5.32** There was an effective system for collecting DNA samples taken in custody. Custody staff were able to explain the force retention and disposal policy for DNA.

Areas for improvement

- 5.33** **Voluntary attendees should not be booked into custody within the custody suite environment.**
- 5.34** **Detainees should be re-read their rights and entitlements in the presence of their appropriate adult.**

Communication

- 5.35** A professional telephone interpreting service was available to assist in the booking-in process. Suitable double-handset telephones were available in all the suites, with the exception of Swansea, where this service was used via loudspeaker telephones, which lacked privacy and could be difficult to hear when the suite was busy. Staff told us that a face-to-face interpreter service was available for interviews but there had been some delays in utilising this service due to the language involved. This resulted in some detainees remaining in custody for longer than necessary or having to be bailed to return at a later date. Hearing loops were not available in any of the custody suites.
- 5.36** Custody staff were able to access legal rights and entitlements documents in a range of different languages when required (and also in Braille; see paragraph 5.4), but not all staff were aware that an easy-read pictorial version of the rights and entitlements documents was also available for detainees needing help with understanding or reading.
- 5.37** In the 10 cases we reviewed, bail periods were realistic and proportionate; however, a clear rationale was not always recorded to justify bail being the appropriate course of action. Practices for managing and monitoring bail cases were variable across the four custody suites. In data supplied by the force, the average length of detention pre-bail for the year to the end of March 2016 was just under 10 hours.

Complaints

- 5.38** There was no information displayed about the complaints process in any of the custody suites. This information was contained in the rights and entitlements notice offered to all detainees but this was rarely accepted (see also paragraph 5.29). Custody staff gave us mixed responses when asked how they would handle a complaint. Some said that it would depend on whether the complaint related to a custody matter or another issue. While some staff

told us that they would notify an inspector, others said that they would tell the detainee to make their complaint at the front desk or telephone 101 (see paragraph 4.1) on release. We saw a detainee at Cardiff Bay who wished to make a complaint being told to write to the local superintendent once he had left the custody suite, despite the bronze custody inspector being present in the custody suite at that time.

Area for improvement

- 5.39 Detainees should be routinely informed about how to make a complaint about their care and treatment and should be able to do this before they leave custody.**
(Repeated recommendation 5.34)

Section 6. In the custody cell, safeguarding and health care

Expected outcomes:

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent health care practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

- 6.1** The newer custody suites at Bridgend and Merthyr Tydfil were clean and well maintained. The Cardiff Bay suite was shabby and, because of the high throughput, we were not assured that all cells were thoroughly cleaned between uses. Swansea was by far the poorest facility, and during the inspection we found dirty cells and a bad smell throughout the suite. Showers were generally clean but did not always afford sufficient privacy and we were concerned by obvious ligature points in some designated washing areas, which we notified local staff about.
- 6.2** The risks presented by most of the obvious ligature points in cells had been addressed since the previous inspection. Formal checks of cells for issues including ligature points and cleanliness were no longer conducted daily or with any consistency in any of the suites. As a result of an incident at Merthyr Tydfil, where a detainee had secured a ligature using the sink and bedding, pillows had been removed from all suites and cells with sinks. We considered this to be a disproportionate response.
- 6.3** After booking in, detainees were escorted to their cell by a DO or one of the custody sergeants. The use of cell equipment, such as the emergency call bell and intercom, was not always explained to detainees. Cell bells were generally answered promptly. However, in our case audits we were concerned to find that a cell bell at Bridgend had been muted for an hour, and some staff told us that they would do this if detainees pressed the bell constantly.
- 6.4** All suites had a fire evacuation policy, which staff understood. We were not provided with any specific details about when fire evacuations had taken place.
- 6.5** CCTV operated in all suites but signs to alert detainees to this fact were not in clear view of detainees, and they were not told about it during the booking-in process. We spoke to a woman at Merthyr Tydfil before her release and she said that she had not used the toilet during her time in the cell as she was concerned that she would be viewed on CCTV. Staff had not told her that the toilet area was not covered.

Areas for improvement

- 6.6** **Staff should conduct and record daily cell checks, including identification of ligature points.**
- 6.7** **The practice of muting cell call bells should cease with immediate effect.**

Safety – use of force

- 6.8** Oversight and governance of the use of force were inadequate. We were not confident that police officers and custody staff were held accountable or that managers were aware of the use of force in custody suites. A new electronic use of force form had been introduced on 1 April 2016, and it was expected that all staff involved in any incident involving the use of force would complete it. However, at the time of the inspection this was not happening and in many cases we reviewed, the form had not been completed. There was also little information in detention logs to justify the use, or type, of force. There was no qualitative information contained in the new form; we were told that it was used purely to gather data. There was no monitoring of trends in relation to the use of force, and staff were unable to tell us how often it was used, or under what circumstances (see area of concern 2.50).
- 6.9** Most staff we spoke to said that they had undertaken officer safety/personal protection training within the previous 12 months. Data provided showed that some officers had not completed the training within this timeframe, and we were also told that police officers with over five years' service received refresher training only every two years, which was unacceptable (see also paragraph 3.7 and area for improvement 3.11).
- 6.10** We reviewed the CCTV footage of 10 incidents, and a further six custody records recording the use of force against detainees. CCTV recordings were routinely kept for only 30 days, so we were unable to review all the footage referred to in custody records. Most incidents had been handled well and reflected sensitive treatment of the detainee. However, we had concerns in a small number of cases about the proportionality of responses and referred these to the force for their further consideration. In one of the cases, force had been used to remove clothing because of a perceived risk of self-harm with what appeared to be too little negotiation or communication with this detainee beforehand. In two incidents involving the same detainee, who had attempted to bite and spit at staff, a piece of anti-rip clothing seemed to have been used to cover his face. This was not an approved piece of equipment and could have restricted the detainee's breathing. Many staff said that they did not feel able to deal effectively with detainees who behaved in this way and often resorted to unapproved techniques to manage it. We were not assured that managers reviewed CCTV footage to assure themselves that the force used had been proportionate to the risks posed or to identify any learning points (see area of concern 2.50).
- 6.11** Senior managers told us that Tasers had not been used in custody within the previous 12 months and we were assured that they would only be used in exceptional circumstances.
- 6.12** Many detainees arrived in custody in handcuffs. Local practice was generally that these would not be removed until permission was given by the custody sergeant. This meant that many compliant detainees remained in handcuffs for long periods and were often searched while handcuffed, which was uncomfortable for them and disproportionate to the threat posed in the controlled custody environment (see area of concern 2.50).
- 6.13** In the previous year, there had been 3,245 strip-searches across all custody suites. This appeared high but represented a considerable reduction since the previous inspection. From the records we were able to review, we found that there had been a reasonable rationale for strip-searches being carried out and that generally they had been authorised properly. We had some concerns that this was an area of work which the force was not monitoring. Most strip-searches were conducted in rooms without CCTV coverage. However, we saw some examples where clothing had been removed in cells, with no effort made to cover the CCTV monitors in the booking-in areas. This compromised the dignity of the detainee.

Areas for improvement

- 6.14 Handcuffs should be removed immediately from detainees in holding areas unless a risk assessment indicates the need for restraints, for the safety of staff and others.**
- 6.15 The number of strip-searches conducted across the force should be monitored, to ensure that they are carried out with appropriate justification and authorisation. These searches should be conducted in private.**

Detainee care and PACE reviews

- 6.16** Food and drink were provided at mealtimes and on request. Microwave meals, porridge and breakfast bars were available. Food preparation areas were clean and well equipped. In our CRA, 69% of the detainees had been offered a meal, and this included all those detainees (14) who had been held for over 24 hours.
- 6.17** Mattresses were provided but were not always cleaned between uses. The stocks of blankets that we saw were clean but these were not always offered to detainees during the day. Most cells contained toilets but detainees had to ask for toilet paper as it was not routinely available in the cells. The view of the toilet area was obscured on CCTV images of the cells. There were no hand-washing facilities in the cells at Swansea but these were available on cell corridors. The use of these had to be requested and was subject to the availability of staff.
- 6.18** Custody staff said that they were not always able to offer detainees a shower but would do so if a detainee requested it and there were sufficient staff on duty to facilitate it. In our CRA, only three detainees had been offered a shower, one of whom had been held for over 24 hours. Cotton towels and good stocks of shampoo, soap, toothbrushes and toothpaste were available at all suites. A choice of feminine hygiene products was available only at Merthyr Tydfil and Swansea.
- 6.19** In several of the custody suites, there was a shortage of replacement clothing for detainees whose clothing had been seized for evidential purposes or otherwise soiled. We saw a few detainees wearing, or being offered, anti-rip clothing when no other clothing was available, and staff told us that they would also offer detainees paper suits in these circumstances. Both of these practices were unacceptable.
- 6.20** Shoes were routinely removed from detainees, even when they did not have shoelaces. Plimsolls and foam slippers were available in all the suites but were not routinely offered to detainees. We saw numerous detainees, across all the suites, walking about either in their bare feet or wearing socks. At Swansea, we saw a detainee who had been released from custody seated in the police station reception area wearing a pair of ripped foam slippers, which was degrading and inappropriate.
- 6.21** All the custody suites had at least one outside exercise area for detainees. However, we did not see any of these being used; in our CRA, only six detainees (4%) had been offered outside exercise, and this had not included any of the detainees held for over 24 hours. We were told that it was not always possible to facilitate exercise during busier times but that, when it was, detainees would be locked in the exercise area and monitored via CCTV from the booking-in areas. This practice presented an element of risk as several of the exercise areas had potential ligature points (drains in the floor and open-wire roofing), and the high levels of graffiti in some yards suggested a lack of staff monitoring.

- 6.22** A limited range of reading materials was available for detainees, usually provided by staff, but these were generally provided only on request. There was no material for children, in languages other than English, or in easy-read format. In our CRA, only one detainee had been offered access to reading materials while detained. Not all suites had designated visits facilities but in those that did, staff told us that they would only allow visits in exceptional circumstances. During the inspection, a young man (18 years of age) in custody at Merthyr Tydfil who was experiencing some mental health difficulties was allowed a visit with his mother in a closed visits room (see also paragraph 5.4).
- 6.23** Reviews of detainees' cases were undertaken by BCU inspectors or, in their absence, by the custody inspectors. Some of the face-to-face reviews we observed were timely and appropriate, but others were conducted late and not all inspectors asked detainees if they had any representations to make. In our CRA, of the 90 detainees who required an initial review, 32 had been conducted early, the earliest being only one hour and 37 minutes after the detainee had arrived into custody. We saw no detainees being told that reviews had taken place while they were asleep. Custody sergeants confirmed that information about such reviews was not exchanged during handovers or flagged on Niche (see paragraph 4.2), and therefore could be overlooked. At Merthyr Tydfil, we heard the BCU inspector attempt to conduct a review over the telephone with a young male in his cell. In our CRA, we found that an initial review of a child had been conducted over the telephone and not in person.

Areas for improvement

- 6.24 All detainees held overnight, and those who require this, should be offered a shower and exercise.**
- 6.25 Detainees not wearing adequate clothing should be offered suitable alternatives.**
- 6.26 Reviews of detention should be conducted in accordance with the Police and Criminal Evidence Act 1984, code C.**

Safeguarding

- 6.27** Custody staff did not receive any specific training in the safeguarding of children or vulnerable adults at risk. There was no force-specific safeguarding policy. Staff we spoke to were generally aware of local referral mechanisms to the public protection unit but some deferred this to officers in the case, which was poor practice.
- 6.28** There was a higher threshold for strip-searching children, and in our CRA only one child had been subjected to such a search. Other than increased observations, there was no other specific support or care for children. They were mostly located in cells in the vicinity of adults and given little additional attention. There was no additional screening to identify any extra support needs while detained and no access to age-appropriate books to keep them occupied while in custody. Girls under 18 were not routinely allocated a female member of staff to be responsible for their care (see also paragraph 5.2).
- 6.29** Too many children remained unnecessarily in custody overnight (see also paragraph 3.25 and area of concern 2.48). We were concerned to find that police custody in Merthyr Tydfil had been used as a place of safety for a 16-year-old boy (who had not been arrested) because suitable alternative accommodation could not be found for him. Data provided by the force also showed that during 2015/16, four children had been detained in police custody under section 136 (see paragraph 3.10), which was also inappropriate.

- 6.30** Most AAs for children in custody were parents or relatives. They were not given written guidance about the role they were expected to perform. The AA service provided for children was delivered by the youth offending services across seven local authorities during office hours, and by the emergency duty team thereafter. In our CRA, case audits and observations, there were often long delays in custody staff contacting AAs. In our CRA, all children had had an AA at some stage in the process. The average time for an AA to arrive had been two hours 41 minutes and the longest wait was 11 hours 40 minutes. The force was aware that the emergency duty team service to the custody suites was too limited.
- 6.31** The AA service for vulnerable adults was commissioned by the PCC and provided by Hafal. The service operated 24 hours a day and we were consistently told that it was a good service for vulnerable adults detained in police custody. In our CRA, 21 adult detainees had accessed an AA. However, in our case audits we discovered that some detainees identified as having mental health issues had not had an AA called quickly enough, or at all. We also found examples where vulnerable adults had had their fingerprints and photographs taken without the presence of an AA, and we also observed this practice during the inspection. In most cases, the AA had been summoned to arrive only in time for the interview, which meant that they would not have been able to support the child or vulnerable adult throughout their period in custody.
- 6.32** There were infrequent meetings with representatives from the youth offending services and emergency duty team to discuss the overall service. However, meetings involving a new South Wales working group, including partner agencies, were due to take place soon after the inspection, to address wider issues about the detention of children, including the AA service.

Areas for improvement

- 6.33** **Girls under 18 should be allocated a named female officer who is responsible for their care while in custody, which is a requirement under section 31 of the Children and Young Persons Act 1933.**
- 6.34** **Detainees should have access to appropriate adults (AAs) from the point of booking into custody. The force should ensure that AAs are requested to attend as soon as possible, to ensure the welfare and safety of vulnerable adults and children in custody.**

Governance of health care

- 6.35** A health needs assessment had been completed in September 2013 for the Cardiff Bay custody suite (which was said to be representative of the force area), but was now out of date. The police commissioned the Mitie Group to provide physical health services for detainees. Health services had improved since the previous inspection and detainees we spoke to expressed satisfaction with access to health care.
- 6.36** Data for the three months to the end of March 2016 indicated that around 81% of responses by Mitie had been within target times. Contract monitoring was effective and performance was subject to a 'points' system when breaches occurred, so that accumulated points would lead to a contract 'rectification'. The latter did not include financial penalties – which was unusual. There were well-developed structures for monitoring clinical governance. Complaints and adverse incidents were rare.

- 6.37** A nurse health care professional (HCP) covered Bridgend and Cardiff custody suites, and one covered Merthyr Tydfil and Swansea suites. Twenty-four-hour cover was provided, and the HCPs were complemented by a forensic medical examiner (FME), who was available by telephone or to visit the custody suites. Mitie checked the credentials of their clinical staff, offered probationary support to new staff members, provided ongoing group peer supervision and good training. A professional telephone interpreting service was available to support detainees whose first language was not English.
- 6.38** Multi-agency working was strong, with relevant information-sharing protocols between the police, Mitie and relevant others.
- 6.39** Clinical examinations were conducted confidentially and in private unless risk assessment suggested otherwise. Detainees could usually choose the gender of the HCP, although this would lead to a longer wait.
- 6.40** Generally, clinical rooms were of a high standard, except at Swansea, which was not fit for purpose. Clinical rooms there were clean but the attached toilet facilities were being used as storage areas, which was inappropriate. Work surfaces at some suites were unsuitable for forensic sampling, particularly at Swansea. The force was aware of new requirements related to the forensic sampling of genetic materials.
- 6.41** We did not see paper roll examination couch covers but were told that they were available in forensic examinations packs. Control of infection required attention as we did not see hand-washing guidance displayed and some taps were of the wrong design to minimise contamination.
- 6.42** The protocol for resuscitating collapsed detainees had improved. There were automated external defibrillators (AEDs) at all the custody suites. Other resuscitation equipment, including small oxygen cylinders, was situated in the clinical rooms. We did not see reserve cylinders, which would be of value in protracted resuscitation situations. Custody staff were trained to use the AEDs and HCPs were trained appropriately in intermediate life support. Equipment was subject to regular, documented checks, so a state of readiness was assured.

Patient care

- 6.43** In our CRA, 39 (26%) detainees had required the services of an HCP while detained. We observed appropriate assessment and evidence-based treatment of detainees, and those we spoke to appreciated the care they had received.
- 6.44** Detainees had access to an HCP by request or after referral by custody staff. Custody staff called the Mitie medical response centre when an HCP was required. We were impressed to see that custody staff liaised with HCPs about potential referrals, and some HCPs saw detainees immediately, before receiving telephone instructions from the response centre.
- 6.45** Processes for gaining patient consent, and storing and managing clinical records were consistent with expected contemporary NHS standards. HCPs summarised their interventions with detainees in the custody record, and also explained the treatment to custody staff, who expressed satisfaction with this arrangement.
- 6.46** The timely response of ambulance services was not guaranteed and many custody staff told us about extensive waits they had experienced. A new initiative to find solutions to various ongoing problems – including ambulance service response times – was due to start imminently with a multi-agency process mapping workshop.

- 6.47** Detainees' own medications – including those prescribed in custody – were kept securely with their property until the time for administration. Custody staff had access to a small stock of over-the-counter medications, which could be given to detainees for self-administration following authorisation by the FME. There was a useful range of signed patient group directions (which authorise appropriate HCPs to supply and administer prescription-only medicine) and detainees could take their prescribed medications with them to court, if necessary.
- 6.48** Subject to validation, patients on opiate substitution therapy (usually methadone) could receive it while in custody – although only the FME could administer it. There was good availability of symptomatic relief for withdrawal from drugs and alcohol, but detainees in custody for long periods had no access to smoking cessation therapy.
- 6.49** Medication management, including stock control, storage, administration and disposal of drugs, was good, with daily, documented counts of controlled drugs.

Areas for improvement

- 6.50** **Health care professionals (HCPs) should be able to assist detainees to self-administer prescribed opiate substitution therapy in line with PACE code C.**
- 6.51** **Nicotine replacement therapy should be available to detainees who require it.**

Good practice

- 6.52** *HCPs saw detainees before receiving instruction from the call centre, demonstrating a high level of trust between custody staff and HCPs, and saving time in assessing detainees who needed prompt attention.*

Substance misuse

- 6.53** G4S offered well-developed and effective substance misuse services. G4S was the lead agency and custody 'gateway' to the Dyfodol consortium pathway, assessing about 500 detainees per month. Detainees we spoke to were satisfied with the support offered.
- 6.54** At Cardiff and Swansea, there was an intensive drug intervention programme (DIP), with embedded arrest referral workers (ARWs) for 12 hours a day, a partial service at weekends, testing on arrest and intelligence-led testing. There were plans to introduce the DIP to all the suites in the force area in the current year, which would give the police greater support. However, this had not happened as anticipated following the previous inspection.
- 6.55** ARWs in Bridgend and Merthyr Tydfil provided services to the courts and police custody, visiting the police custody suites at least twice daily – although working hours were variable. When ARWs were unavailable, custody staff made referrals to G4S, which ARWs picked up the following morning. ARWs also saw detainees who had assessment and treatment as a condition of bail.
- 6.56** ARWs made appropriate entries in custody records and explained their approaches to custody staff, who appreciated their support. ARWs, mental health practitioners and custody staff were co-located at Bridgend and Merthyr Tydfil, which enabled effective communication.

- 6.57** G4S appropriately sought to divert detainees with substance misuse and alcohol issues into recovery programmes and provide guidance on harm minimisation. Needle exchange was available from token-operated vending machines at Cardiff and Swansea and there were plans to install similar machines at the other two suites. Naloxone was available in police custody and to take home, which indicated a good approach to safety.

Mental health

- 6.58** Mental health services were provided by local health boards – Abertawe Bro Morgannwg University Health Board at Bridgend and Swansea; Cardiff and Vale University Health Board at Cardiff; and Cwm Taf Health Board at Merthyr Tydfil. Despite the complex provision, the police described communications and partnership working as being very good. There was a relevant mental health crisis call concordat, and its implementation was monitored (see also paragraph 3.24). Police custody staff had good training in mental health awareness, and mental health practitioners (MHPs) were confident in the abilities of their police colleagues.
- 6.59** Models of liaison and diversion varied between health boards, and differences in the working day, working week and availability of MHPs led to inconsistencies in access to mental health services between custody suites. When MHPs were unavailable, Mitie were called to conduct mental health assessments, and crisis teams accepted the referral of allied health professional general nurses, which we welcomed as it enabled quicker access to mental health services. MHPs summarised their interventions in the custody records and we observed excellent communications with custody staff.
- 6.60** Before the inspection, on two consecutive Saturdays (the first, a particularly busy Saturday – the day of an international rugby game), a pilot study had taken place, whereby MHPs had been based in the public service centre, to provide triage (see also paragraph 4.6). This had proved to be very successful and pointed the way towards further development of the mental health liaison and diversion services. The Keep Safe Cymru card, carried by some detainees with a learning disability (see paragraph 4.2), was said to be a ‘passport’ to improved efficiency of care.
- 6.61** In the six months to the end of March 2016, 78 detainees had entered police custody under section 136 of the Mental Health Act. Although this was far fewer than in the same period in the previous year (167), it was still unacceptably high. Since 1 April 2016, the use of police custody for individuals detained under section 136 had been banned (except for violent detainees). Early signs were encouraging, with no such detainees entering custody and several custody sergeants saying that they had diverted these detainees away from police custody.
- 6.62** Attendance by crisis team members to undertake Mental Health Act assessments was said to be prompt during working hours, although there were long waits out of hours as emergency duty team workers were often busy with child safeguarding in the community.

Good practice

- 6.63** *Mental health crisis teams’ acceptance of mental health referrals from Mitie general nurses meant that the time between the detainee being seen and referred was shorter, which was more efficient.*

Section 7. Release and transfer from custody

Expected outcomes:

Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

- 7.1** In our case audits, recording of pre-release risk assessments was mostly poor: they generally contained little information, we could not be assured that all identified risks had been addressed and it was often unclear how detainees were getting home. However, our observations provided assurance that the work practice was actually better than reflected in the records. Custody sergeants were properly focused on securing a safe release for detainees. Initial risk assessments and care plans were revisited to ensure that all identified risks had either been addressed or were manageable. Some suites were located in areas where public transport links were limited. Sergeants ensured that detainees had the means to get home; when this was not the case, they arranged transport by police officers. We were told that some suites held small floats of petty cash to pay for fares home if required. A support leaflet was available on the back of charge/bail sheets but was not always brought to the attention of detainees and was not always provided to those who were released without charge. Sergeants were aware of the offences and circumstances that made detainees more at risk on release. There was a further support leaflet available and provided to detainees charged with a sexual offence.
- 7.2** The quality of the person escort records (PERs) we examined was variable, with some containing little information but others being completed to a high standard. Additional printed information was often attached and the whole document was inserted into a bespoke brown envelope, which could be annotated to specify what it included, such as medical or police national computer information.

Courts

- 7.3** Custody staff at most of the suites told us that the local remand courts would normally accept detainees up to 3–4pm on weekdays and sometimes as late as 10.30am on Saturdays, with some limited flexibility on a day-to-day basis. This was an improvement on the situation at the time of the previous inspection.
- 7.4** At Swansea, detainees in handcuffs were sometimes walked across the road to the local magistrates' court by police officers. This made detainees potentially vulnerable to public insult and curiosity, and media attention.

Area for improvement

- 7.5** **Detainees should be transferred to court in a manner that protects them from insult, curiosity, and public and media attention.**

Section 8. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

8.1 Area of concern: The force was not sufficiently effective within its strategic partnerships to ensure good outcomes for children. A particular area of concern was the lack of local authority accommodation provision for children who had been charged and refused bail, resulting in children being detained in police custody unnecessarily.

Recommendation: South Wales Police should engage with their counterparts in the local authority to instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells. (2.48)

8.2 Area of concern: We saw many arresting officers discussing the reason and grounds for arrest with custody sergeants without the detainee being present. Sergeants did not always then attempt to confirm whether or not the detainee had fully understood the reason for their arrest.

Recommendation: Detainees should always be present when the arresting officer explains the reason and grounds for their arrest to the custody sergeant. (2.49)

8.3 Area of concern: All aspects of the use of force lacked governance and effective oversight. The force did not record data on the use of force in custody effectively. Despite the availability of a new use of force form, not all staff submitted one following involvement in an incident involving the use of force. Some staff did not receive training every year or were out of date with training. Unapproved equipment was used to assist in the restraint of detainees.

Recommendation: South Wales Police should maintain effective management oversight of use of force incidents and trends. Incidents involving force should be quality assured and cross-referenced with closed-circuit television. All staff involved in incidents in which force is used should complete individual use of force forms. Staff should be adequately trained in a range of techniques that are appropriate for a custodial setting, at least every 12 months. Force should only be used at the lowest level and be commensurate with the threat posed, and only approved equipment should be used. (2.50)

Areas for improvement

Leadership, accountability and partnerships

8.4 The force should ensure that all of its officers are fully compliant with the national training requirements for use of force. (3.11)

8.5 The force should develop clear policies and procedures for safeguarding, supported by training, to ensure that these issues are always identified and acted on. (3.12)

- 8.6** Dip-sampling of custody records should be increased to around 10% of the throughput of custody, to allow for a representative and meaningful sample and to facilitate organisational learning. (3.21)

Pre-custody: first point of contact

- 8.7** All staff should be trained in the Mental Capacity Act 2005 to enable them to respond effectively to individuals who might be mentally vulnerable. (4.9)

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

- 8.8** Staff should be trained to recognise and provide for the individual needs of detainees, particularly children, women, detainees with disabilities and those who are transgender. (5.8)
- 8.9** Custody staff should ask all detainees if they have any obligations as carers or are being cared for by others, and whether they need help to address these. (5.9)
- 8.10** Anti-rip proof clothing should only be used in exceptional circumstances and as a last resort, to protect the detainee from harm. There should be a recorded rationale, based on a risk assessment, and the detainee's own clothes should be returned to them at the earliest opportunity. (5.19)
- 8.11** Removal of detainees' clothing, footwear and other items should be subject to individual risk assessment. (5.20)
- 8.12** Rousing checks should be recorded and include full details, including the detainee's condition. (5.21)
- 8.13** All custody staff should carry anti-ligature knives in the custody suites at all times. (5.22)
- 8.14** All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (5.23, repeated recommendation 4.19)
- 8.15** Voluntary attendees should not be booked into custody within the custody suite environment. (5.33)
- 8.16** Detainees should be re-read their rights and entitlements in the presence of their appropriate adult. (5.34)
- 8.17** Detainees should be routinely informed about how to make a complaint about their care and treatment and should be able to do this before they leave custody. (5.39, repeated recommendation 5.34)

In the custody cell, safeguarding and health care

- 8.18** Staff should conduct and record daily cell checks, including identification of ligature points. (6.6)
- 8.19** The practice of muting cell call bells should cease with immediate effect. (6.7)

- 8.20** Handcuffs should be removed immediately from detainees in holding areas unless a risk assessment indicates the need for restraints, for the safety of staff and others. (6.14)
- 8.21** The number of strip-searches conducted across the force should be monitored, to ensure that they are carried out with appropriate justification and authorisation. These searches should be conducted in private. (6.15)
- 8.22** All detainees held overnight, and those who require this, should be offered a shower and exercise. (6.24)
- 8.23** Detainees not wearing adequate clothing should be offered suitable alternatives. (6.25)
- 8.24** Reviews of detention should be conducted in accordance with the Police and Criminal Evidence Act 1984, code C. (6.26)
- 8.25** Girls under 18 should be allocated a named female officer who is responsible for their care while in custody, which is a requirement under section 31 of the Children and Young Persons Act 1933. (6.33)
- 8.26** Detainees should have access to appropriate adults (AAs) from the point of booking into custody. The force should ensure that AAs are requested to attend as soon as possible, to ensure the welfare and safety of vulnerable adults and children in custody. (6.34)
- 8.27** Health care professionals (HCPs) should be able to assist detainees to self-administer prescribed opiate substitution therapy in line with PACE code C. (6.50)
- 8.28** Nicotine replacement therapy should be available to detainees who require it. (6.51)

Release and transfer from custody

- 8.29** Detainees should be transferred to court in a manner that protects them from insult, curiosity, and public and media attention. (7.5)

Good practice

In the custody cell, safeguarding and health care

- 8.30** HCPs saw detainees before receiving instruction from the call centre, demonstrating a high level of trust between custody staff and HCPs, and saving time in assessing detainees who needed prompt attention. (6.52)
- 8.31** Mental health crisis teams' acceptance of mental health referrals from Mitie general nurses meant that the time between the detainee being seen and referred was shorter, which was more efficient. (6.63)

Section 9. Appendices

Appendix I: Inspection team

Ian Macfadyen	HMI Prisons team leader
Vinnett Percy	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Norma Collicott	HMI Constabulary inspection lead
Vijay Singh	HMI Constabulary inspection officer
Patricia Nixon	HMI Constabulary inspection officer
Anthony Davies	HMI Constabulary inspection officer
Paul Tarbuck	HMI Prisons health services inspector
Joe Simmonds	HMI Prisons researcher
Helen Ranns	HMI Prisons researcher

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Treatment and conditions

Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Main recommendations

Cells should be free of ligature points or, when resources do not allow this, the risks presented managed. (2.19)

Partially achieved

The conditions at the custody suite at Pontypridd should be significantly improved to address the safety issues presented. (2.20)

No longer relevant

Detainees with mental health problems (under section 136) should be diverted to the appropriate specialist services and police custody should be used only exceptionally for this purpose. (2.21)

Partially achieved

Recommendations

Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women. (4.8)

Partially achieved

Booking-in desks should allow effective and private communication between detainees, staff and their legal representatives. (4.9)

Partially achieved

The risk assessment and care planning process should be to a consistent high standard. (4.17)

Achieved

The use of strip searching should be monitored and any potential over-use investigated and corrected. (4.18)

Partially achieved

All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.19)

Not achieved (Recommendation repeated, 5.23)

CCTV coverage should be installed at Pontypridd, Neath and Ton Pentre custody suites. (4.20)

No longer relevant

The policy on handcuffing should be clarified to avoid this becoming the norm and cuffs should be removed as soon as possible after arrival at the custody suite. (4.25)

Not achieved

South Wales Police should collate the use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance, and the memorandum of understanding with health partners should exclude handcuffing to beds. (4.26)

Not achieved

CCTV images of toilet areas should be obscured. (4.44)

Achieved

All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.45)

Not achieved

The use of paper suits should be reduced by making more track suit tops and bottoms available. (4.46)

Not achieved

Detainees, especially those held for longer periods, should be offered outside exercise and all exercise yards should be kept clean and free from ligature points. (4.56)

Not achieved

Individual rights

Detainees are informed of their individual rights on arrival and can freely exercise those rights while in custody.

Recommendations

The quality and consistency of pre-release risk assessments should be improved. (5.12)

Achieved

Custody staff should always ensure that detainees' dependency obligations are routinely identified and, where possible, addressed. (5.13)

Not achieved

Senior police managers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody and police custody staff should ensure that detainees are taken promptly to court either by the prisoner escorting company or, where there are delays, by alternative transport. (5.27)

Achieved

South Wales Police should review the arrangements in place at Cardiff Bay custody suite to facilitate detainees being able to consult legal representatives in private and to ensure that existing processes are not acting as an inhibitor. (5.28)

Achieved

Appropriate adults should be available out of hours for juveniles and to support juveniles aged 17. (5.29)

Partially achieved

South Wales Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.30)

Not achieved

Detainees should be routinely informed about how to make a complaint about their care and treatment and should be able to do this before they leave custody. (5.34)

Not achieved (Recommended repeated, 5.39)

Health care

Detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

Main recommendation

Detainees with mental health problems (under section 136) should be diverted to the appropriate specialist services and police custody should be used only exceptionally for this purpose. (2.21)

Partially achieved

Recommendations

All clinical rooms should be fit for purpose and meet current infection control requirements. (6.9)

Achieved

There should be formal information sharing policies between South Wales Police and all providers of health services. (6.10)

Achieved

South Wales Police should ensure that detainees held in custody needing to see a health care practitioner can do so within the agreed timescales. (6.20)

Achieved

Detainees across the force area should have access to mental health liaison and diversion schemes. (6.36)

Partially achieved