Report on an unannounced inspection visit to police custody suites in

North Wales

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

29 September - 3 October 2014
Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our ‘Guide for writing inspection reports’ on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/
Contents

Section 1. Introduction 5
Section 2. Background and key findings 7
Section 3. Strategy 13
Section 4. Treatment and conditions 17
Section 5. Individual rights 23
Section 6. Health care 29
Section 7. Summary of recommendations and housekeeping points 33
Section 8. Appendices 37
  Appendix I: Inspection team 37
  Appendix II: Progress on recommendations from the last report 39
Section 1. Introduction

This report is part of a programme of 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.

In January 2014, the Home Secretary asked HM Inspectorate of Constabulary (HMIC) to undertake a thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. It was decided by HMIC and HM Inspectorate of Prisons to use the existing rolling programme of police custody inspections to facilitate the principal fieldwork. The inspection of police custody suites in North Wales forms part of this fieldwork, and the findings will inform the final thematic report which is to be published in 2015.

Shortly before our inspection, North Wales Police used our joint inspection criteria to undertake their own assessment of their custody operation, which was commendable. Their assessment was a considered and transparent appraisal; however, it could have been improved further by identifying action to address areas of concern, for example, working with local authorities to improve the provision of alternatives to detaining children in custody.

Custody was mostly well-managed, but some data collection and analysis was inadequate. These included recording use of force and requests for alternative accommodation for children facing detention in police custody. There was positive, effective communication and good management structures; and meetings were productive. Robust quality assurance was in place. There were good provisions for learning and disseminating information among staff, who told us they had ready access to the intranet that included a newsletter on custody issues. During our previous inspection of North Wales in 2010 we were very critical of the poor conditions at Wrexham. We were glad to find that the suite had been improved, and plans were well advanced for the provision of a new custody suite there. Staff told us they had been consulted about the plans.

Detainees we spoke to told us they felt cared for. Staff related to them in a professional and courteous manner, using excellent interpersonal skills. Staff were able to identify vulnerabilities and in most instances they provided the appropriate level of detainee care. However, we were concerned that at St Asaph, far more detainees than at the other suites were strip-searched and the reasons for this discrepancy had not been identified.

There was a good focus on upholding detainees’ rights. Alternatives to arrest were well used and custody sergeants refused detention where appropriate. With some notable exceptions, detention times were mostly kept to a minimum. Legal representatives told us they believed detainees were well cared for and their rights were properly respected. However, we were concerned that appropriate adult services were of variable quality. The appropriate adult service provided by the local authority during office hours was less accessible than the out-of-hours service provided by a contractor.

Health care in custody was generally good in spite of some limitations associated with staff shortages. Health care practitioners (HCPs) and custody staff worked well together in ensuring that detainees’ health care needs in custody were met. Detainees spoke positively of their contact with HCPs. We found that detainees who needed treatment were provided with sufficient medication to last while they were at court, which is good practice that is unusual. Substance misuse services were also held in high regard.
All detainees who needed a mental health intervention were seen by a HCP. The mental health provider accepted referrals from nurses, which was very good. It was positive that for a year there had been a significant reduction in the use of police custody as a place of safety for section 136 patients, but very recently the number of people detained by police officers under section 136 and taken to hospital had risen significantly. North Wales Police should satisfy itself that officers are using their powers under section 136 proportionately and appropriately.

We noted that, of the 24 recommendations made in the report of our inspection in September 2010, 14 recommendations had been achieved, seven had been partially achieved and three had not been achieved.

This report recognises a range of achievements by North Wales Police in their custody provision. It makes a number of recommendations to the force and the Police and Crime Commissioner concerning the comparatively small number of areas where outcomes for detainees were less good, to help the force address those as well. We expect an action plan to be provided in due course.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

May 2015
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 College of Policing 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 Custody1 about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 This was the second inspection of North Wales Police, the first being in September 2010. Since then there had been some reduction in the custody estate and plans for Wrexham custody suite had progressed to agreed funding for a replacement.

2.4 North Wales has three full-time custody suites and two part-time suites, comprising 89 cells in total. The designated custody suites and cell capacity of each is as follows:

<table>
<thead>
<tr>
<th>Custody suite</th>
<th>Number of cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caernarfon</td>
<td>16</td>
</tr>
<tr>
<td>Dolgellau (part-time)</td>
<td>7</td>
</tr>
<tr>
<td>Holyhead (part-time)</td>
<td>10</td>
</tr>
<tr>
<td>St Asaph</td>
<td>32</td>
</tr>
<tr>
<td>Wrexham</td>
<td>24</td>
</tr>
</tbody>
</table>

Strategy

2.5 There was a strategic focus on police custody matters and a clear line management structure up to and including the assistant chief constable (ACC). The custody estate was in good condition, except for Wrexham. There was a range of internal meetings at which custody matters were discussed and staff told us they were consulted about the design of the new suite, which was good. Monthly performance data were discussed at these meetings, including a good range of qualitative data to provide reassurance to managers and chief

1 http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm
officers of the standards of custody in North Wales Police. The constitution and breadth of these meetings appeared to work well, with good outcomes for staff and detainees.

2.6 Custody sergeants told us that they felt empowered to refuse further detainees when they were at full capacity for the resources available. At the time of the inspection, suites were not very busy and staff levels seemed proportionate to demand. Staff comprised of permanent custody sergeants and detention officers (DOs), but we were told that in exceptions, at times of high demand or staff shortages, overtime was being offered to police constables (PCs) to carry out the duties of DOs. Prior to them commencing these duties all constables needed to complete specific custody training, have been properly briefed by Custody Sergeants, and ordinarily supported by a trained DO.

2.7 North Wales Police were involved in a number of strategic partnerships, including a protocol with health which had resulted in a significant reduction of patients held in custody under section 136 Mental Health Act 1983. These arrangements were commendable and needed to be replicated with local authorities for children in custody.

2.8 Relationships with independent custody visitors appeared good and the Police and Crime Commissioner provided scrutiny. The force collected data of police requests and outcomes for local authority accommodation for young people who were held in police custody, but this was not systematically analysed.

2.9 Quality assurance was very good. It included dip sampling, peer reviews and learning from adverse incidents, all with an audit trail for learning and development activities. Staff had good access to a range of policies and procedures on the intranet, including links to other sources of learning and a newsletter on custody issues. North Wales Police were not recording use of force in custody in accordance with the Association of Chief Police Officers’ policy and College of Policing guidance, and plans to implement procedures for doing so had yet to be finalised.

2.10 A self-assessment had been undertaken against the police custody expectations criteria. Overall this was a positive approach to improving care and standards in custody and we intend this report to provide some helpful observations for the next self-assessment.

Treatment and conditions

2.11 Detainees were treated courteously by custody staff who were very knowledgeable about the diverse needs of detainees. Staff had excellent interpersonal skills and detainees we spoke to said they felt cared for.

2.12 There was a lack of privacy for detainees being booked in which could inhibit disclosures about health relevant to the risk assessment, management and safety of detainees and staff. Detainees were also vulnerable to being overheard by other people being booked in.

2.13 The focus on diversity had generally improved, but further improvement was needed to safeguard the dignity of women detainees, particularly at Wrexham, where there were few cells with toilets and detainees needed to be accompanied. Most custody teams were male, and a female detainee had to notify a male custody officer that she needed the toilet and wait until a female officer became available to accompany her.

2.14 We saw few young people booked in to custody and there appeared to be a good understanding that young people should not be detained overnight. Staff told us that local authorities did not provide secure accommodation but in some cases foster care was available.
2.15 Wheelchairs and crutches were provided in suites and staff told us they were offered to and used by detainees. Staff explained how they communicated with people with learning disabilities and in Wrexham and Caernarfon there was an easy-to-read leaflet explaining the custody process.

2.16 Religious books and artefacts were stored appropriately and readily produced for use by detainees. Diversity was understood by custody staff who described how they conducted searches respectfully in a religious, cultural and gender context.

2.17 Initial risk assessments were thorough and of a high standard, which was supported by our custody record analysis. In all suites cords were routinely removed regardless of risk and in St Asaph custody suite all detainees were placed on 30-minute observations. Otherwise, risk management was individual and dynamic. Custody staff we spoke to were clear how to obtain a response from detainees who were subject to rousing checks.

2.18 There were fewer detainees in anti-rip clothes than at the previous inspection; however, the use of anti-rip clothing was not always supported by a clear rationale.

2.19 We observed a number of handovers which were of an exceptionally high standard. All direct custody staff were involved and handovers focused on risk management and vulnerability. Nurses were not included in handovers and the involvement of health care practitioners would have enhanced the already high standard of handovers.

2.20 Most pre-release risk assessments were thorough and some were very good. There was a wide range of support leaflets which were given out regularly. There were examples of detainees being taken home or to hospital.

2.21 In most cases we did not see detainees waiting in handcuffs, except during the Friday night visit when we saw compliant detainees waiting in handcuffs for lengthy periods, which was unnecessary.

2.22 There was no monitoring of use of force in custody which was currently under review by the force. Staff received annual personal safety training and told us they used de-escalation techniques before resorting to force. Leg restraints were available in all custody suites, and staff told us they were rarely used. We were provided with a policy, but staff we asked during the inspection did not know about it.

2.23 Very few strip-searches were conducted at the time of the inspection. Data supplied by the force showed that the number of strip-searches at St Asaph was nearly five times higher than at Wrexham, despite similar throughput at the two suites, which was concerning. In one case, custody staff asked a female detainee to remove all her clothes and put on an anti-rip gown in a cell monitored by CCTV which was visible on the monitor behind the custody desk. This was inappropriate.

2.24 Custody suites were clean, safe and in good repair. Wrexham had improved since our previous inspection but its design and facilities were outdated. Cell checks were undertaken regularly in all suites and faults were addressed promptly.

2.25 Detainee care was good and detainees we spoke to said they felt well cared for and the staff were good. Food and drink was provided as required. Showers were rarely provided, except on request, and at St Asaph one detainee who had been sick on his clothes was not offered a shower.
Section 2. Background and key findings

**Individual rights**

2.26 Voluntary attendance\(^2\) was well used and the data provided demonstrated an overall reduction of throughput in custody suites. Custody sergeants told us that officers were aware of PACE code G\(^3\) and rarely needed to refuse detention because arresting officers generally used powers appropriately. Sergeants told us they occasionally refused detention when health concerns had been identified which indicated that detainees should be sent to hospital or mental health suites.

2.27 We generally saw a focus on minimising detention times, but we also identified some anomalies in the waiting and recording times for booking in which conflicted with the times supplied by the force. This had implications for monitoring accurate detention times and ensuring timely rights and entitlements.

2.28 Staff told us that some immigration detainees stayed between 24 hours and two or three days. Data confirmed that the average time spent in police custody by an immigration detainee in the last 12 months had been just less than 30 hours.

2.29 There were a number of appropriate adult (AA) schemes covering North Wales. Staff told us that the out-of-hours services for young people and vulnerable adults were better than the daytime services. The daytime AA service was provided by the local authority for adults or youth offending teams for children. Staff told us the daytime response was sometimes delayed until the task was assigned to the out-of-hours service, resulting in longer stays in custody for detainees. Although out-of-hours staff would, where possible, attend for interview purposes, they did not always attend in person to offer support and guidance, or at the time of change. Some staff were unaware of the Home Office guide for AAs, and the version in use was out of date.

2.30 Staff reported some difficulties in obtaining face-to-face interpretation services which led to prolonged time spent in custody. Documentation was provided in English and Welsh.

2.31 Although there were sufficient PACE Codes of Practice available in the suites, several of them were earlier versions and therefore out of date. Legal advisers were routinely given copies of custody records and those we spoke to mentioned good relationships with custody staff and an adherence to explaining their rights to detainees. We saw several PACE reviews across the suites, which were thorough and timely. Our custody record analysis (CRA) showed that detainees were not always reminded that a review had taken place while they were asleep.

2.32 Custody staff told us that courts closed unreasonably early and detainees were sometimes held in police custody for longer than necessary. Officers were able to make an arrest on warrant and take detainees direct to court, if court listings could accommodate it and person escort records were in order. This was beneficial.

2.33 Detainees wishing to complain could make their complaint to an inspector if one was available, or they had to submit their complaint after they left police custody.

---

\(^2\) Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.

\(^3\) PACE Code G refers to the Police and Criminal Evidence Act 1984, Code G, which is the code of practice for the statutory power of arrest by police officers.
Healthcare

2.34 Clinical supervision was limited because of staff shortages. There was evidence of audit of clinical records by the lead nurse. Medical rooms were generally suitable, although some fixtures and fittings did not comply with minimum infection control standards and the rooms were often not locked when not in use.

2.35 Liaison between health care practitioners (HCPs) and custody staff was positive. HCP responses had been timely until recently when there had been HCP staff shortages. Detainees expressed satisfaction with their consultations. Nicotine replacement therapy was available, but opiate substitution therapy was not available in police custody. There were good practices to ensure that detainees received their prescribed medication while in detention and for alcohol withdrawal while in court.

2.36 We were concerned to hear from staff and HCPs that accident and emergency departments occasionally discharged detainees back to police custody with unresolved issues. It was assumed by the hospital that the detainee would receive better and constant supervision. This was unreasonable and presented significant risks to the detainee and the police.

2.37 Substance misuse services were good. The service had extended hours at Wrexham where detainees were tested on arrest for trigger offences. All detainees were offered access to arrest referral workers (ARWs) and detainees and staff spoke highly of the service.

2.38 Police custody was rarely used as a place of safety for section 136 of the Mental Health Act 1983, which was good. However, there had been a rise of over 50% in the use of section 136 over the last 12 months. This suggested that assurances were required that its use was appropriate.

Main recommendations

2.39 The Police and Crime Commissioner and chief officer group should engage with their counterparts in the local authority and instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 for children. Performance data should be monitored to ensure that young people are not unnecessarily detained in police cells.

2.40 North Wales Police should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers’ policy and College of Policing guidance.

2.41 North Wales police should investigate why strip-searches are disproportionately higher at St Asaph than at other custody suites.

---

4 These are particular offences that could indicate that the detainee has a substance misuse problem.
5 Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone 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 poses an unmanageably high risk to others), the place of safety may be police custody. Section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an approved mental health professional (for example a specialist social worker or nurse), and to make any necessary arrangements for treatment or care.
2.42 North Wales Police should engage with the local accident and emergency services to ensure that custody is not used as an overspill facility for detainees/patients.
Section 3. Strategy

Expected outcomes:
There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the well-being of detainees.

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a central custody function delivered through the partnerships and community safety portfolio business area. A superintendent from the business area managed a chief inspector who was responsible for leading the force custody function.

3.2 Since the last inspection in 2010, the estate had reduced from six full-time suites to three full-time and two part-time suites. The custody estate was in good condition, although the design and facilities at the Wrexham suite were dated. The Police and Crime Commissioners (PCCs) had agreed funding for a new suite at Wrexham in 2016. There were contingency plans for use of custody facilities in neighbouring forces if required.

3.3 Detainees were transported to the custody facility nearest to their place of arrest. We were told that custody sergeants were authorised to decline further detainees when their custody suite had reached capacity based on risk management in their suites. Such decisions were communicated to the custody managers or response inspectors. At Dolgellau, dedicated custody sergeants opened the custody facility on demand only. Holyhead had recently reduced to opening one day a week to deal with detainees who had been bailed to return to the police station. These pragmatic approaches aimed to reduce the need for detainees to travel long distances across a wide force area.

3.4 Staffing levels in custody suites at the time of the inspection were generally adequate. Permanent custody sergeants and detention officers (DOs) were employed by North Wales Police. Dedicated resource planners were responsible for ensuring that rota absences were covered by a process of re-rostering and moving staff between suites. We saw evidence of overtime being offered to police constables (PCs) to act as DOs. We were assured that prior to undertaking such duties they would receive specific custody training. A dedicated pool of response and neighbourhood sergeants who had received initial custody training was also available to cover custody sergeant duties.

3.5 The chief inspector managed three custody managers (inspectors), a custody support inspector and a nursing manager. The inclusion of the nursing manager contributed to integrating health care and delivering good outcomes for detainees (see section on health care). The custody managers provided day, evening and weekend PACE coverage for the custody suites and response inspectors assisted with PACE coverage outside these times. The custody managers line managed the custody sergeants at their respective custody suites.

3.6 Custody sergeants managed DOs who looked after the care and welfare of detainees. DOs provided a good standard of care and all custody staff were professional in their approach. The shift handover process was consistent across the custody suites, and effective sharing of information resulted in good outcomes.

3.7 There was an internal meeting structure for the discussion and review of custody matters. The ACC chaired a six-weekly Operations Board attended by the force custody chief inspector. This board reported to the Force Executive Board, chaired by the Chief
Constable. The PCC held the Chief Constable to account for performance at a scrutiny meeting, where custody data and independent custody visitors’ data were reviewed. The chief inspector chaired a quarterly custody management meeting attended by the custody inspectors and nursing manager and a six-monthly strategic custody forum with internal stakeholders, such as staff associations, facilities department, professional standards department and forensic medical examiners. Monthly performance data were discussed at these meetings, including a good range of qualitative data to reassure managers and chief officers of the standards of custody provision in North Wales. These meetings appeared to work well and provide good outcomes for staff and detainees. The staff consultation meeting chaired by the chief inspector was attended by custody manager, sergeant, DO and custody nurse representatives. Staff said that they had been consulted about the design of the new suite at Wrexham.

Partnerships

3.8 The chief constable chaired the Local Criminal Justice Board and sat on the North Wales regional leadership group, which provided a strategic overview of criminal justice and community safety services across the area. The group was attended by representatives of the PCC and chief executives of partner organisations.

3.9 A protocol with health care partners for dealing with people detained under section 136 Mental Health Act 1983 had resulted in a significant reduction in detainees held in police cells. Only 17 people had been held in police custody under this legislation in the past 12 months. These arrangements were effective with commendable outcomes but needed to be complemented by the provision of secure and non-secure local authority accommodation for young people (see section on treatment and conditions).

3.10 The force custody chief inspector attended the quarterly meetings of the independent custody visitors.

Learning and development

3.11 All custody sergeants and DOs had undertaken an initial three-week custody-specific training course, followed by a period of mentoring, before carrying out custody duties. They also had annual custody refresher training informed by the quality assurance processes, which was commendable.

3.12 There was a structured quality assurance process for dip-sampling custody records which involved peer review by custody managers and sergeants of custody records from other suites. This was overseen by the custody support inspector and the force custody chief inspector. Custody managers also attended and reviewed shift handovers. The force had set up a continuous professional development (CPD) database which provided a robust audit trail for all quality assurance processes and wider communication, learning and development.

3.13 Although the force records use of force within the custody suites on the detainee’s custody record, it does not collate this data in a way that would easily enable its examination for trends in accordance with the Association of Chief Police Officers’ policy and College of Policing guidance. A conflict management board had been established to develop and implement a procedure for recording and monitoring the use of force.

3.14 There was an adverse incident procedure referred to as custody incident reporting. The CPD database was used to review, analyse and disseminate learning from this to staff.
3.15 The force intranet site included links to a range of policies and procedures for custody, with annual review dates clearly displayed against each. The site also included links to Independent Police Complaints Commission Learning the Lessons documents. A force-wide newsletter, ‘Need to Know’, was also used to communicate learning and development for custody issues as appropriate.

3.16 North Wales Police had undertaken a comprehensive self-assessment against the HMI Prisons/HMI Constabulary expectations for police custody and a thematic on vulnerable persons in police custody.

Good practice

3.17 The inclusion of the nursing manager in the custody management team reflected the importance of health care provision in the police custody environment.
Section 4. Treatment and conditions

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

Respect

4.1 Custody staff displayed excellent interpersonal skills. They treated detainees with respect and considered their needs throughout their detention. We observed custody sergeants explaining the booking-in process and informing detainees of their rights and access to reading material, meals and drinks. At the time of the inspection, low numbers of detainees were brought into custody. Those whom we spoke to said the staff were good and they felt well cared for.

4.2 If staff considered detainees to be particularly vulnerable because of age, health or mental capacity, they offered additional reassurance. Several detainees in the three main suites were allowed to remain in a holding booth in sight of the booking-in area rather than be placed in a cell. Detainees appreciated this.

4.3 Privacy during booking in was generally lacking. There were no screens separating the booking-in positions and conversations could easily be overheard. This had the potential to inhibit disclosures about health relevant to the risk assessment, management and safety of detainees and staff. Custody sergeants made little attempt to ensure privacy and at Wrexham we observed a detainee being asked risk assessment questions while another stood nearby.

4.4 The focus on diversity had improved since the last inspection. Custody staff had received training, for example on learning disabilities and the impact of detention on women detainees. Some of this learning was evident in their practice. However, the gender balance of staff needed improvement to maintain the dignity of women detainees. At Wrexham, many cells had no toilets and detainees had to ring their cell call bell and ask to be escorted to the toilet. This was particularly demeaning for women when no female custody staff were on duty. Custody staff offered women feminine hygiene products and ensured they were searched only by female officers, but did not routinely ask them if they might be pregnant.

4.5 Rooms were available at all suites for the detention of children and young people. They were almost identical to ordinary cells but often without in-cell toilets. With the exception of Wrexham, these detention rooms were located closer to the custody desk. The standard level of observations for children and young people was every 30 minutes. We saw few young people being booked in during the inspection and most staff told us it was a last resort to keep a young person in custody overnight, which was good. During the inspection, the data relating to the number of young people under the age of 18 who had been held in custody overnight in the previous 12 months, as bail had been refused by the custody officer, was ambiguous and need further clarification. The force later informed us that there were 44 such young people so detained by the police with no record of any of them having been found suitable accommodation by the local authority.

4.6 The provision for older detainees and those with disabilities was reasonable. There were two adapted cells at Caernarfon with lowered cell call bells, hearing loops were available at Wrexham and Caernarfon, and wheelchairs and crutches at all suites were offered to and used by detainees. Thick mattresses were available for detainees who found the bed plinths
Section 4. Treatment and conditions

too low and we saw these in use. Staff explained how they communicated with detainees with learning disabilities and at Wrexham and Caernarfon there was an easy-to-read leaflet explaining the custody process.

4.7 Custody staff understood religious diversity and all suites had a good supply of items for religious observance, including prayer mats, a compass to determine the direction of Mecca and religious books, which were all appropriately stored. Staff had a good awareness of conducting searches which respected a detainee’s culture, religion and gender and how to search transgender detainees appropriately.

Recommendation

4.8 Booking-in areas should allow effective and private communication between staff and detainees. (Repeated recommendation 4.7)

Safety

4.9 We observed detainees arriving at the custody suites and a risk assessment was completed for all of them. Custody sergeants engaged with detainees when they asked them questions from the police custody record system on health, risk and individual need. They asked appropriate supplementary questions in a skilful, sensitive way when detainees disclosed potential risks. Custody sergeants and detention officers (DOs) worked well together: DOs completed checks on the police national computer and shared any warning markers with the custody sergeant. However, we were concerned that detainees were not routinely asked if they were carers and had responsibilities to fulfil with their dependents while they were in custody. Health care practitioners helped custody staff to determine if detainees were fit to be detained and interviewed and how their physical and mental health care needs could be safely managed. All detainees were asked if they wanted to see an arrest referral worker for advice about substance misuse, but little explanation of their role was offered.

4.10 The CRA confirmed that detailed risk assessments were completed to a good standard for all detainees and that observation levels were increased or reduced to reflect changing situations. Despite the very good risk assessments completed at St Asaph, we observed that all detainees were placed on 30-minute observations or 30-minute observations with rousing checks if the detainee was under the influence of alcohol. Custody staff told us that it was standard practice for DOs to visit all detainees at 30-minute intervals. The intention was good but the practice could potentially obscure real individual risks if detainees who were safe to be monitored every hour were not differentiated from those who might need increased supervision. The ‘4-Rs’ mnemonic (rousing procedure as set out in annex H to code C in the Police and Criminal Evidence Act 1984) was only displayed in the cell corridors at St Asaph as an aide memoire for DOs. Custody staff fully understood the importance of obtaining a response during rousing checks.

4.11 Custody staff routinely removed detainees’ shoes and cords from their clothes regardless of the detainee’s risk or previous experience of self-harm. Some staff also told us that they would not permit detainees to take spectacles into cells which suggested a mechanistic approach to risk management.

4.12 Anti-rip gowns were available in the custody suites and custody staff gave several examples of when they would use the gowns, but there was no consistent approach. We saw one detainee with recent warning markers for self-harm placed in an anti-rip gown but he told staff that he was not intending to harm himself. He was placed in a cell monitored by CCTV. The detainee told us he believed he had been placed in the gown because of the level of his
intoxication when he was detained. The custody staff allowed the detainee to wear his own clothes when he left the cell to see his solicitor. Staff told us that the use of anti-rip gowns had greatly reduced since the previous inspection, but no records were kept of when they were used. Use of anti-rip clothing was not always correctly noted in care plans.

4.13 All suites had some cells which were covered by CCTV and custody staff used CCTV appropriately to observe detainees who concerned them but did not present a sufficiently high risk to be placed on a close proximity watch. All staff carried anti-ligature knives.

4.14 At the previous inspection no formal handover time was built into each shift. This was no longer the case and we observed a number of handovers which were consistently of an exceptionally good standard and in some cases exemplary. Handovers focused on risk management and vulnerability and all custody staff were involved, but not health care nurses. The process could be further enhanced by the involvement of health care and by incoming sergeants visiting the detainees following the handover.

4.15 Pre-release risk planning was better than we usually see. When custody sergeants had strong concerns about a detainee’s welfare, they arranged a fitness-to-release interview with the HCP. HCPs confirmed this but said they had seen many detainees who had no apparent need for such an assessment. At Wrexham, an elderly man who was being investigated for historic sexual abuse was assessed by the HCP. She ensured that he knew about help lines and telephoned his wife, in his presence, to ask if she would support him. A man who had taken a recent overdose was given an appointment with a psychiatric nurse at the local hospital and on release police officers took him to his appointment. There were excellent leaflets about local sources of support including specialist leaflets for ex-forces personnel. A national leaflet for sex offenders with details of the Stop it Now helpline was issued by investigating officers. The CRA confirmed that support leaflets were given out regularly and that most vulnerabilities were identified. There were examples of detainees being taken home or to hospital.

4.16 At St Asaph, which was in a remote location, North Wales Police provided taxi fares to the local town or arranged other transport home for released detainees.

Recommendations

4.17 Detainees’ spectacles, shoes and cords should only be removed if a risk assessment deems it necessary.

4.18 The use of anti-rip gowns procedures should be clarified with staff to ensure that they are used only when risk factors indicate that they are necessary. (Repeated recommendation 2.23)

4.19 Health care practitioners should be included in the handover process and detainees should be visited by incoming custody sergeants.

4.20 All detainees should be routinely asked if they are responsible for dependents who might be affected by their detention.

Housekeeping point

4.21 The ‘rousing’ aide memoire should be displayed in all custody suites.
Use of force

4.22 We saw very few detainees arrive at the suites in handcuffs and those who did had them removed promptly on arrival. The exception to this was during a night visit at St Asaph where we saw several intoxicated detainees held in handcuffs in police vehicles for up to 40 minutes awaiting entry to the custody suite, which was unacceptable. Custody sergeants appropriately asked if any force had been used before arrival at the custody suite and this was recorded on the custody system. A separate use of force form was no longer available to allow scrutiny or analysis of data to identify trends. This was an area of risk, and we were told that the force was reviewing the position (see section on strategy).

4.23 All custody staff had received personal safety training and annual personal safety refresher training.

4.24 Leg restraints were available in all custody suites and staff told us that they were rarely used. We were provided with a policy, but staff we asked during the inspection did not know about it.

4.25 We observed very few strip-searches. Data provided by the force indicated that the throughput of detainees was similar at Wrexham (6,070) and St Asaph (6,161), but the number of strip-searches conducted in the 12 months before the inspection was 73 and 322 respectively. This was concerning. In one case, custody staff asked a female detainee to remove all her clothes and put on an anti-rip gown in a cell monitored by CCTV which was visible on the monitor behind the custody desk. This was inappropriate.

Recommendations

4.26 Detainees should be admitted to the custody suite in a timely way. Handcuffs should be removed from detainees after their arrival, unless a risk assessment indicates otherwise.

4.27 Detainees should not be observed via CCTV when their clothes are being removed.

Physical conditions

4.28 Wrexham custody suite was much cleaner than at the previous inspection but its design and facilities were very outdated. Some cells lacked natural light and many had no toilets. North Wales Police had plans to close and replace this suite by 2016.

4.29 St Asaph and Caernarfon suites were safe, light and clean and relatively modern. Holyhead and Dolgellau, although a little older and much less busy, continued to be of a good standard.

4.30 Cells were checked between each occupancy and there was a formal cell checking process daily and weekly. This was quality assured by the custody managers and any cell defects were promptly addressed by the estate management department. DOs responded promptly to cell call bells. We saw detainees being placed in cells by DOs but they were not always told when or how to use the cell call bell. Toilet images on CCTV were obscured but not all detainees knew that.
Section 4. Treatment and conditions

4.31 Staff at each suite were knowledgeable about fire evacuation procedures and told us that there had been fire drills in the recent past. Adequate stocks of handcuffs were readily accessible.

Housekeeping points

4.32 The use of cell call bells should be explained to all detainees.

4.33 All detainees should be told that they cannot be viewed by CCTV when using the toilet.

Detainee care

4.34 Detainee care was generally good and detainees we spoke to said that staff were good and they felt well cared for. Clean mattresses were available in all cells but not all suites had pillows. There was an ample supply of clean blankets and we saw custody staff at all suites offering them to detainees.

4.35 Detainees whose clothes were removed for evidence or hygiene were offered jogging trousers, sweatshirts and plimsolls, which were available in different sizes. Paper underwear was also available. At Wrexham and Caernarfon any clothing that detainees could not keep in their cell with them was left carelessly on the floor outside their cell.

4.36 There was an ample supply of toiletries and feminine hygiene packs but not of safety razors for detainees wishing to shave before attending court.

4.37 All suites had clean showers with reasonable privacy. Custody staff said that they were not always able to offer showers and would usually do so if a detainee requested it and there were enough staff. Our CRA confirmed that none of the four detainees released to court, all of whom had spent more than 12 hours in custody (one 31 hours), had been offered washing facilities. At St Asaph a detainee who had vomited in his cell and been placed in anti-rip clothing had not been offered a shower the next morning. Toilet paper was provided in most but not all cells.

4.38 All suites had a good stock of microwave meals and cereal bars suitable for a range of dietary needs. Staff provided more than one meal if necessary. We saw meals being offered to newly arrived detainees outside normal meal times.

4.39 There was an outside exercise yard at all suites for detainees’ use, covered by CCTV. We saw detainees in the exercise yard at some of the custody suites but in our CRA only three detainees in our sample (10%) had received outside exercise. These detainees had been in detention for 14, 23 and 31 hours. It was apparent that such exercise was offered during custody reviews.

4.40 There was a small supply of reading material at all suites, but little for young people or in foreign languages. In two suites staff had brought in used magazines but they did not proactively offer detainees anything to help pass the time. Our analysis indicated that only one detainee in the sample had been offered anything to read. Suitable closed social visit rooms were available at all the suites. We were told that social visits could be facilitated but rarely were.
Recommendations

4.41 All detainees held overnight and those who require one should be offered a shower, which they should be able to take in private.

4.42 Detainees should be offered time outside in an exercise yard.

Housekeeping points

4.43 Pillows should be provided at all suites.

4.44 Detainees’ clothes should be stored appropriately.

4.45 A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before they leave or attend court can do so.

4.46 A small supply of toilet paper should be available in every cell, subject to risk assessment.

4.47 A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for detainees whose first language is not English.

4.48 Social visits should be facilitated if appropriate.
Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants checked with arresting officers the reasons for detention to ensure that they were appropriate. Sergeants told us that they rarely had to refuse detention because officers were aware of the criteria in PACE Code G\(^6\). They had occasionally refused to authorise detention when health concerns had been identified.

5.2 Voluntary attendance\(^7\) was available as an alternative to custody which custody staff believed was well used, particularly for distant rural locations. Data confirmed that the use of voluntary attendance had increased to 787 attendees from September 2013 to August 2014 compared with 77 over the same period in 2011 to 2012. Detainee throughput had dropped by over 2,000 over the same period.

5.3 All custody staff were aware of the need to keep detention periods to a minimum, and custody sergeants were clear about their obligation to progress cases quickly. At Wrexham we saw a detainee who had been arrested, interviewed and bailed within two hours without being placed in a cell. Our CRA showed that the average detention time was 9 hours 32 minutes and 40% of detainees were held for less than six hours. This reflected data supplied by the force.

5.4 We observed most detainees being booked in promptly after arrival at the custody suites, but custody sergeants did not always ask arresting officers for their time of arrival at the suites. In at least two cases, detainees had waited in a queue for up to 15 minutes and the booking-in rather than the arrival time had been recorded. This gap in the timeline had implications for ensuring timely rights and entitlements. Data supplied by the force showed average waiting times from arrival in custody to authorisation of detention of five minutes at Caernarfon and Wrexham and nine minutes at St Asaph, which were not accurate in the light of the practices that we had observed.

5.5 Custody staff reported a good relationship with Home Office immigration enforcement officers and two North Wales police officers were on secondment with the department at the time of the inspection. Immigration detainees who were to be transferred to immigration removal centres were usually moved within 24 hours, although some remained in the custody suites for up to two or three days. Data supplied by the force indicated that 112 immigration detainees had been held in the past 12 months with an average time in custody of about 30 hours.

\(^6\) PACE Code G refers to the Police and Criminal Evidence Act 1984, Code G, which is the code of practice for the statutory power of arrest by police officers.

\(^7\) Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.
5.6 Staff told us that the custody suites were never used as a place of safety for children under Section 46 of the Children Act 1989, which had not been the case at our previous inspection in 2010.

5.7 Custody staff were clear about their responsibility to contact an appropriate adult (AA) when dealing with vulnerable adults or young people under the age of 18 years. Family or friends were contacted in the first instance, but, if they were not available, the police contacted the local youth offending teams (YOTs) or social services. In some areas the service for young people was provided by The Appropriate Adult Service (TAAS) outside working hours, while elsewhere the out-of-hours service for young people and vulnerable adults was provided by the social services emergency duty team (EDT). Staff told us that the out-of-hours services were more efficient than the office hours services: detainees held in the late afternoon often had to wait for an AA to attend from the out-of-hours service because nobody from the daytime service was able to attend.

5.8 There were five (17%) young people aged between 15 and 17 in our CRA sample. They all had an AA present while their rights were read and during interview. Two of the young people had had protracted waits for an AA. One young person had arrived in custody just before 11.30pm. He had originally wished a family member to act as an AA but was unable to provide contact details. An AA from the YOT was eventually contacted at 10.33am the following day and they attended at 12.02pm at the same time as the young person’s solicitor. There was no justification for this delay and no thought appeared to have been given to asking the AA to attend in the meantime. Another young person had arrived in custody intoxicated and was placed on an eight-hour rest period. Her mother was contacted shortly after she arrived but was advised that the interview would not be conducted until the morning and she should not arrive until then. Her mother attended 8 hours 46 minutes after the young person arrived in custody.

5.9 We spoke to a member of staff from the EDT at St Asaph who was acting as AA for a vulnerable adult. He left after the detainee’s interview was concluded and a charging decision was being awaited. The detainee was subsequently charged at 3.35am the following morning and it was disappointing that another member of the EDT acted as an AA over the telephone rather than attend in person to support the detainee. We were advised that this happened frequently and was a pragmatic approach to dealing with the large geographical distances across the force area.

5.10 Some custody sergeants did not know that a guidance document was available for family members or friends acting as an AA, and it was not always issued. The document available to staff was out of date.

5.11 A telephone interpretation service was available to assist in the booking-in process. We observed this happening via loudspeaker telephones, which were noisy and lacked privacy. Staff told us that the interpretation service was often unable to provide face-to-face interpreters, which had caused delays for detainees while alternative interpreting sources were considered. At Caernarfon during the inspection the service had been contacted at 3.40am to provide an Albanian interpreter and again at 8.50am when they said they could not provide a face-to-face interpreter. An alternative service provided an interpreter who arrived at the custody suite at 2.30pm. In our CRA one detainee had requested a Turkish interpreter who had arrived five hours later. Such delays were unacceptable. Documentation was available in English and Welsh.

---

Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.
During booking in, custody sergeants advised detainees of their three main rights and offered a written notice setting out rights and entitlements while in custody. Several versions of this notice were available across the three full-time custody suites, only one of which was up to date. Custody staff knew how to obtain these documents in foreign languages and we saw these being issued on a number of occasions. No record was kept of this. Custody staff were not aware of an easy-read pictorial version of the rights and entitlements, which was available on the Home Office website.

**Recommendations**

5.13 **Custody sergeants should ask arresting officers their time of arrival with detainees and ensure that this is accurately recorded.**

5.14 **Appropriate adults should be readily available in person at all times to support young people and vulnerable adults while they are in custody.**

**Housekeeping points**

5.15 Family or friends acting as appropriate adults should be issued with an up-to-date written guide to assist them in carrying out this role.

5.16 Double-handset telephones should be provided in all suites to facilitate telephone interpretation.

5.17 The force should ensure that interpreters can be provided promptly.

5.18 Out-of-date versions of the rights and entitlements notice should be withdrawn from use.

5.19 All custody staff should be made aware of the availability of the rights and entitlements information in an easy-read pictorial format.

**Rights relating to PACE**

5.20 Detainees were told during the booking-in process that they could read the PACE codes of practice, but these were not routinely shown or explained by custody staff. Very few copies of the up-to-date PACE Code C were readily available in the custody suites, but there were several out-of-date copies. Not all suites displayed a poster informing detainees of their right to free legal advice.9

5.21 All detainees were offered free legal representation but detainees who wished to receive telephone advice from legal advisers had to use a telephone located at the custody desks, which lacked privacy. There were sufficient consultation and interview rooms for detainees to speak privately to their legal advisers. We saw legal advisers routinely being offered custody records for inspection. In our CRA, all detainees had been offered legal advice and 20 (67%) had accepted. In all cases solicitors had been contacted promptly. We saw custody

---

9 The Criminal Defence Service has produced a poster titled ‘You need a solicitor’; this explains to detainees that they are entitled to legal advice free of charge and this message is reproduced on the poster in a range of languages. We expect to see this poster, or an equivalent version, displayed in every police custody suite.
sergeants asking detainees why they had declined legal advice and advising them that they could change their mind at any time. Legal advisers told us of good relationships with custody staff and adherence to their clients’ rights.

5.22 We observed detainees being told that they could inform someone of their arrest, which staff facilitated, but this was not always recorded.

5.23 Reviews of detainees were undertaken by dedicated custody and operational inspectors across the force area. We saw some good face-to-face reviews by inspectors, which were timely.

5.24 In our CRA, of the 17 records where initial reviews had been required, nine had been conducted on time, seven early and one late. Most of the reviews had taken place face to face, but four reviews had taken place while the detainee was asleep. There was no record of the detainees being informed of this nor that they had been reminded of their rights and entitlements.

5.25 There was an effective system for collecting DNA samples taken in custody.

5.26 The local magistrates’ courts did not usually accept detainees after 2pm on weekdays and after 9am on Saturdays, which was too early. Detainees who were not charged until later in the morning remained in custody overnight. We found several unacceptable examples of courts refusing to receive detainees. At Wrexham, a detainee had been refused by the court at lunchtime and had had to stay a further night, which custody sergeants said was not uncommon. At St Asaph, a woman had been arrested on a warrant on a Saturday morning. The arresting officers had taken her directly to court, trying but failing to alert the court by telephone. When they arrived at court, staff refused to accept the detainee because they had not received a telephone call. The detainee was kept in police custody until the following Monday morning.

5.27 Person escort records (PERs) were completed for all detainees travelling to court and most PERs that we examined were completed to a high standard. A prisoner escort contractor was available for morning and afternoon courts, but staff chose to take detainees in police vehicles for afternoon courts to ensure they did not remain in custody for longer than necessary. Officers who made an arrest on warrant could take the detainee directly to court, provided that a PER had been completed and that the court accepted the detainee. This was a good initiative.

Recommendations

5.28 Detainees should be able to have a private telephone consultation with their legal adviser.

5.29 Senior police managers should work with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary.

Housekeeping points

5.30 There should be sufficient copies of the up-to-date PACE codes of practice in all custody suites and these should be routinely shown and explained to detainees by custody staff.

5.31 Posters detailing detainees’ right to free legal advice in a range of languages should be prominently displayed in all custody suites.
5.32  Detainees who are asleep at the time of a review and whose continued detention is
authorised should be informed about the decision and reasons as soon as practicable after

Rights relating to treatment

5.33  If detainees wished to make a complaint, they advised the custody inspector or operational
inspector and the inspector noted the complaint while the detainee was still in custody.
Inspectors confirmed that they would take the complaint depending on its nature and their
availability at the time. If the inspector was not in a position to note the complaint, the
detainee was given information, such as the force website address, contact telephone
numbers and postal addresses, to enable the complaint to be pursued by other means once a
detainee had been released.
Section 6. Health care

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

Governance

6.1 North Wales Police provided the in-house medical service. Health care practitioners (HCPs) – three registered nurses and a forensic medical examiner (FME) - were available to the police 24 hours a day although, because of temporary staffing issues, only two nurses were available on occasions. There was no cover of nursing HCPs between 5pm and 7pm when only FMEs were available. Despite this, there was no evidence that health outcomes for detainees had been affected.

6.2 The police scrutinised the HCPs’ professional credentials, provided induction, mandatory training and some financial support for clinical training. Clinical supervision had been curtailed because HCPs were not available; it was intended to re-establish clinical supervision as nursing staff levels returned to normal. The senior nurse, who was the nursing manager, was part of the custody management team (see section on strategy).

6.3 There were good arrangements for strategic and operational management of the HCPs and some performance data were available via the custody dashboard (electronic digest of information). In 2014, there had been an average of 835 attendances a month by nurses to the end of August, and 332 new detainee assessments a month. There had been about 150 calls a month to an FME, with seven attendances. We observed very positive working relationships between custody staff and HCPs.

6.4 Each site had a medical room and those at St Asaph and Caernarfon were very modern. Cleaning schedules were displayed and rooms were very clean. No room had a clinical work surface suitable for forensic sampling. Some fixtures and fittings did not fully comply with minimum infection control standards, for example tap fittings were of the wrong type. Medical rooms were often not locked when not in use and they were sometimes used for other purposes, which introduced the potential for contamination.

6.5 Each custody suite had an emergency bag of essential medical equipment, an automated external defibrillator (AED) and oxygen, usually sited at the custody desk; they were supplied, maintained and regularly checked by the ambulance service. All custody staff undertook resuscitation training, including the use of the AEDs. Drugs for emergency use were accessible.

6.6 The management of clinical records complied with statutory requirements; the lead nurse sampled records to ensure consistency of quality.

6.7 The storage of medicines in clinical rooms, stock management and disposal of discarded medications were very good, with clear audit trails. Daily and weekly checks were undertaken by HCPs. We noted a controlled drug counting error at St Asaph, which we observed being addressed. Prescribed medications were not stored securely on the booking-in desk bridges at St Asaph and Caernarfon: action was taken immediately to provide secure storage.
6.8 There were patient group directions (PGDs)\(^{10}\) in each medical room and nurses administered medicines supplied under PGDs. Pre-prepared single dose bottles of tablets were used for the police to assist detainees with self-administration of tablets.

**Recommendations**

6.9 **Clinical rooms and practices should comply with relevant standards of infection control and contemporary standards for preventing contamination and forensic sampling.**

6.10 **Medical room doors should be locked when not in use to prevent contamination.**

**Good practice**

6.11 *The use of single dose bottles of medication, prepared by the pharmacist, enabled safer administration of medications.*

**Patient care**

6.12 In our CRA, 40% of detainees had been seen by an HCP. Custody records sometimes did not note the time that the HCP was contacted to attend and it was not possible to calculate an average waiting time. From available data the longest appeared to be about 2 hours 25 minutes and the shortest 45 minutes. Response times were informally monitored by custody sergeants and they generally expressed satisfaction with the service.

6.13 Detainees were treated respectfully and sensitively. There had been only three complaints in two years, about medications. Detainees expressed satisfaction following consultations and custody officers were happy with HCP contacts.

6.14 There was a systematic approach to medical assessment, and evidence-based guidance materials were available on site and on the computer. Clinical records were handwritten and generally of a good standard. HCPs made entries directly on to the custody computer system and then checked with custody staff if explanation was required to enable continuity of care.

6.15 We were concerned to hear from custody staff and HCPs that, occasionally, accident and emergency departments discharged detainees back to police custody with unresolved medical issues, based on assumptions about the level of care available in police custody. We noted a recent case where a detainee had been returned to police custody with an expectation of constant observations - including medical neurological examinations - which was unreasonable and not achievable. The condition of the detainee became worse, necessitating a return to the accident and emergency department. We were pleased to see that the lead FME raised the case with the medical director of the hospital.

6.16 In our CRA, 47% of detainees who arrived in custody were on medication; subject to authentication, this was continued and the police made reasonable attempts to collect prescribed medications from detainees’ home addresses. Opiate substitution therapy was

---

\(^{10}\) Enable the supply and administration of prescription-only medicine by persons other than a doctor or pharmacist, usually a nurse
not available in police custody, which was an omission partially met by symptomatic relief. Nicotine replacement therapy was available and appreciated by detainees. HCPs ensured that detainees requiring symptomatic relief for alcohol withdrawal were able to receive medication while in court custody, which was unusual.

### Recommendation

**6.17** Opiate substitution therapy should be available to detainees in police custody, in line with national guidance.

### Substance misuse

**6.18** In our CRA, 13% of detainees entered custody with alcohol or drug dependencies. Arrest referral workers (ARWs) were present in the custody suites from 7am to 5pm with extended hours at Wrexham, where test on arrest for trigger offences was in place. Custody staff referred detainees with mandated treatment requirements at Wrexham and treatment as a condition of caution was available at all suites. All detainees were asked if they wanted to see an ARW, but little explanation of their role was offered (see section on treatment and conditions). ARWs offered prompt support for adults with drug and alcohol issues and access to substance misuse treatment and harm minimisation services; they followed up out-of-hours referrals.

**6.19** Detainees with alcohol problems were signposted to appropriate services. Detainees under 18 years of age were signposted to specialist young persons’ services. Detainees and custody staff thought highly of the substance misuse services.

### Mental health

**6.20** Betsi Cadwaladr University Health Board provided mental health services in North Wales with a court-based liaison and diversion service. In our CRA, 17% of detainees said they had entered custody with mental health problems and 27% with current or previous self-harm or suicide issues. Custody staff had received training in mental health awareness during induction and had access to NCALT (National Centre for Applied Learning Technologies e-learning package) training thereafter; views on the effectiveness of NCALT in learning were mixed. Strategic and operational partnership arrangements between the police and the Board were very good and discussions about a street triage project in Wrexham had started.

**6.21** No mental health practitioners (MHPs) were working in police custody. All detainees suspected of having a mental health problem were seen by HCPs. The mental health provider accepted referrals from nurse HCPs, which was unusual and commendable. In 2014 to date, only 2.2% of HCP assessments had resulted in referrals to MHPs. There was no needs analysis. Crisis and community mental health teams were available in North Wales but the police had no direct contact with them and did not telephone them for advice.

**6.22** Detainees requiring formal assessment under the Mental Health Act were seen by emergency duty teams; custody officers said that responses were prompt.

**6.23** During the 12 months to September 2014, 505 people had been detained under Section 136 of the Mental Health Act, although only 17 had entered police custody, which was commendable. Eleven per cent of the 505 had subsequently been detained under the Mental Health Act, 20% were admitted to hospital voluntarily and 3% accepted community mental
health support, which represented a caring rather than custodial pathway for these detainees. Police officers’ use of Section 136 to detain people in places of safety other than police stations had increased by over 50% in the last year. The reasons for this increase were unknown and assurances were needed that their use of this power was appropriate.

**Recommendations**

6.24 There should be an analysis of the need for mental health practitioners to be available to detainees in police custody in North Wales.

6.25 The police and HCPs should have access to telephone advice from the mental health services.

**Housekeeping point**

6.26 North Wales police should investigate the increase in the use of section 136, to satisfy themselves that their powers are being exercised proportionately.
Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 The Police and Crime Commissioner and chief officer group should engage with their counterparts in the local authority and instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 for children. Performance data should be monitored to ensure that young people are not unnecessarily detained in police cells. (2.39)

7.2 North Wales Police should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers’ policy and College of Policing guidance. (2.40)

7.3 North Wales police should investigate why strip-searches are disproportionately higher at St Asaph than at other custody suites. (2.41)

7.4 North Wales Police should engage with the local accident and emergency services to ensure that custody is not used as an overspill facility for detainees/patients. (2.42)

Recommendations

Treatment and conditions

7.5 Booking-in areas should allow effective and private communication between staff and detainees. (4.8)

7.6 Detainees’ spectacles, shoes and cords should only be removed if a risk assessment deems it necessary. (4.17)

7.7 The use of anti-rip gowns procedures should be clarified with staff to ensure that they are used only when risk factors indicate that they are necessary. (4.18)

7.8 Health care practitioners should be included in the handover process and detainees should be visited by incoming custody sergeants. (4.19)

7.9 All detainees should be routinely asked if they are responsible for dependents who might be affected by their detention. (4.20)

7.10 Detainees should be admitted to the custody suite in a timely way. Handcuffs should be removed from detainees after their arrival, unless a risk assessment indicates otherwise. (4.26)

7.11 Detainees should not be observed via CCTV when their clothes are being removed. (4.27)

7.12 All detainees held overnight and those who require one should be offered a shower, which they should be able to take in private. (4.41)

7.13 Detainees should be offered time outside in an exercise yard. (4.42)
Individual rights

7.14 Custody sergeants should ask arresting officers their time of arrival with detainees and ensure that this is accurately recorded. (5.13)

7.15 Appropriate adults should be readily available in person at all times to support young people and vulnerable adults while they are in custody. (5.14)

7.16 Detainees should be able to have a private telephone consultation with their legal adviser. (5.28)

7.17 Senior police managers should work with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary. (5.29)

Health care

7.18 Clinical rooms and practices should comply with relevant standards of infection control and contemporary standards for preventing contamination and forensic sampling. (6.9)

7.19 Medical room doors should be locked when not in use to prevent contamination. (6.10)

7.20 Opiate substitution therapy should be available to detainees in police custody, in line with national guidance. (6.17)

7.21 There should be an analysis of the need for mental health practitioners to be available to detainees in police custody in North Wales. (6.24)

7.22 The police and HCPs should have access to telephone advice from the mental health services. (6.25)

Housekeeping points

Treatment and conditions

7.23 The ‘rousing’ aide memoire should be displayed in all custody suites. (4.21)

7.24 The use of cell call bells should be explained to all detainees. (4.32)

7.25 All detainees should be told that they cannot be viewed by CCTV when using the toilet. (4.33)

7.26 Pillows should be provided at all suites. (4.43)

7.27 Detainees’ clothes should be stored appropriately. (4.44)

7.28 A stock of disposable razors should be maintained so that, subject to risk assessment, detainees who wish to shave before they leave or attend court can do so. (4.45)

7.29 A small supply of toilet paper should be available in every cell, subject to risk assessment. (4.46)
7.30 A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for detainees whose first language is not English. (4.47)

7.31 Social visits should be facilitated if appropriate. (4.48)

Individual rights

7.32 Family or friends acting as appropriate adults should be issued with an up-to-date written guide to assist them in carrying out this role. (5.15)

7.33 Double-handset telephones should be provided in all suites to facilitate telephone interpretation. (5.16)

7.34 The force should ensure that interpreters can be provided promptly. (5.17)

7.35 Out-of-date versions of the rights and entitlements notice should be withdrawn from use. (5.18)

7.36 All custody staff should be made aware of the availability of the rights and entitlements information in an easy-read pictorial format. (5.19)

7.37 There should be sufficient copies of the up-to-date PACE codes of practice in all custody suites and these should be routinely shown and explained to detainees by custody staff. (5.30)

7.38 Posters detailing detainees’ right to free legal advice in a range of languages should be prominently displayed in all custody suites. (5.31)

7.39 Detainees who are asleep at the time of a review and whose continued detention is authorised should be informed about the decision and reasons as soon as practicable after waking, in accordance with section 15, Code C, PACE Act 1984. (5.32)

Health care

7.40 North Wales police should investigate the increase in the use of section 136, to satisfy themselves that their powers are being exercised proportionately. (6.26)

Good practice

7.41 The inclusion of the nursing manager in the custody management team reflected the importance of health care provision in the police custody environment. (3.17)

7.42 The use of single dose bottles of medication, prepared by the pharmacist, enabled safer administration of medications. (6.11)
# Section 8. Appendices

## Appendix I: Inspection team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maneer Afsar</td>
<td>HMIP team leader</td>
</tr>
<tr>
<td>Gary Boughen</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Peter Dunn</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Vinnett Pearcy</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Fiona Shearlaw</td>
<td>HMIP inspector</td>
</tr>
<tr>
<td>Heather Hurford</td>
<td>HMIC inspector</td>
</tr>
<tr>
<td>Paul Davies</td>
<td>HMIC inspector</td>
</tr>
<tr>
<td>Vijay Singh</td>
<td>HMIC inspector</td>
</tr>
<tr>
<td>Paul Tarbuck</td>
<td>HMIP health services lead inspector</td>
</tr>
<tr>
<td>Stephen Eley</td>
<td>HMIP health services inspector</td>
</tr>
<tr>
<td>Joe Simmonds</td>
<td>HMIP researcher</td>
</tr>
</tbody>
</table>
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.

Strategy

There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the well-being of detainees.

Recommendations

The force should review the current management arrangements for custody and staffing levels to ensure the care and welfare of detainees. (3.12) Achieved

The force should collate the use of force data and monitor the use of force locally and at force-wide level, for example by ethnicity, location and officer involved. (3.13) Not achieved

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

The use of self-harm prevention smocks should be reviewed and procedures clarified to ensure that they are used only when risk factors indicate they are necessary. (2.23) Partially achieved (recommendation repeated, 2.24) Achieved

When appropriate, detainees should be roused to elicit a response. (2.24) Achieved

Checks should be put in place to ensure that alarm bells are not disabled other than in exceptional circumstances and detainees in cells without in-cell sanitation have access to toilet facilities when required. (2.25) Achieved

The environment at the Wrexham custody suite should be improved and deep cleaned. (2.26) Achieved

Recommendations

Booking-in desks should allow effective and private communication between detainees and staff. (4.7) Not achieved (recommendation repeated, 4.)
There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.8)
**Partially achieved**

An overlap period should be built into all shifts, to facilitate an effective handover between staff. (4.14)
**Achieved**

The toilet should be obscured or blanked out on closed-circuit television screens covering cells with integral sanitation. (4.26)
**Achieved**

All detainees held overnight, or who require one, should be offered a shower. (4.27)
**Not achieved**

Food should be of a sufficient quality and calorific value to sustain detainees for the duration of their stay. (4.34)
**Achieved**

Detainees held for long periods should be offered outdoor exercise. (4.38)
**Partially achieved**

**Individual rights**

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

**Recommendations**

Custody suites should not be used as a place of safety for juveniles. (5.9)
**Achieved**

Custody staff should ensure that detainees’ dependency obligations are routinely identified and, where possible, addressed. (5.10)
**Partially achieved** (recommendation repeated,

Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.16)
**Partially achieved**

Detainees should be told how to make a complaint and should be facilitated to do so before they leave custody. (5.19)
**Achieved**
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

All detainees should be able to see a health care professional appropriate for their needs, including the administration of controlled drugs, within a reasonable time. (2.27)

Achieved

Recommendations

There should be robust infection control procedures for all the clinical rooms, which should be clean. (6.9)

Partially achieved

Medications should only be prescribed and administered in line with relevant professional guidance. (6.10)

Achieved

All detainees who require the services of a drugs or alcohol worker should be referred appropriately, irrespective of the time of day. (6.28)

Achieved

The care of detainees with mental health problems in police custody should be the subject of strategic discussions between chief officers and the health board to develop and implement robust protocols to ensure the health board promptly fulfil their responsibilities to provide detainees with mental health problems with the medical care they require. (6.36)

Partially achieved

Police custody should be used as a place of safety for section 136 assessments only in extreme cases. (6.37)

Achieved

Custody staff should undergo mental health awareness training. (6.38)

Achieved