Report on an unannounced inspection visit to police custody suites in

Gwent

by HM Inspectorate of Prisons

and

HM Inspectorate of Constabulary and Fire & Rescue Services

10–20 July 2017

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.

We last inspected Gwent Police custody in September 2012, when we found that, in most respects, there was a reasonably good standard of provision. Our two principal concerns were about weaknesses in medical provision and the support provided to detainees on release.

During this inspection, we were pleased to find that the majority of detainees in police custody were treated with respect and consideration, and were held safely in good conditions.

The collation and extraction of data from force information systems was better than we normally find, and performance was well understood. However, this did not extend to all key areas of activity, in particular the use of force in custody, where there were frailties in governance.

The overall quality of custody records was poor. This was disappointing because the records often did not reflect the standard of work that we observed in practice. We also identified some procedural weaknesses and practices in the way the Police and Criminal Evidence Act (PACE) and its codes of practice were applied. In particular, the force needed to make sure that notices setting out rights and entitlements were given to all detainees.

Despite robust monitoring, as we commonly find on these inspections, children charged and refused bail continued to be held in custody overnight, with very few moved to alternative local authority-provided accommodation. The force needed to strengthen its joint working with local authority partners to ensure that children charged and refused bail were always looked after properly.

It was encouraging to find significant progress in health provision, which had been one of our main concerns at the previous inspection. Following improvements, detainees now received a sound and reliable health care service.

More work was needed to raise the standard of risk assessments for detainees before their release.

Despite the weaknesses identified, overall this was a positive report. Importantly, detainees held in police custody in Gwent are treated decently. We look forward to seeing the force continue this work to make provision for detainees even better.

We noted that of the 22 recommendations made in our previous report after our inspection of 2012, 10 recommendations had been achieved, four had been partially achieved and eight had not been achieved.

This report provides four recommendations to the force and highlights 33 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
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September 2017

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 Inspectorate of Prisons (HMI Prisons) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).[1] 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 Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services 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*[2] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 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.[3] The analysis focused on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report these differences are statistically significant.[4] A total sample of 96 records were analysed.

2.4 A data collection template was completed by the force during the inspection and was based on police custody data for the 36 months prior to inspection. The template requested a range of information including data on the demographics of the custody population, the number of voluntary attendees and average length of time in police detention.

2.5 This was our second inspection of Gwent police custody, following up on our inspection of 11–13 September 2012. During our 2017 inspection, the designated suites and cell capacity were as follows:

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1 This inspection began before 19 July 2017, when HMIC also took on responsibility for fire & rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

2 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

3 95% confidence interval with a sampling error of 7%.

4 A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p<0.01$ was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

Custody suites	Number of cells
Newport	28
Ystrad Mynach – contingency suite	31

Leadership, accountability and partnerships

2.6 Under the direction of the assistant chief constable, Gwent Police had an efficient governance structure, which provided clear accountability. There were generally sufficient staff resources available to ensure that detainees in custody were held safely and treated with respect. The force had adopted national guidance for custody and this was complemented by some local policies. However, not all processes and practices complied with written policy.

2.7 Schemes to divert vulnerable people away from custody were limited but Gwent Police was committed to preventing children coming into the criminal justice system, with some strong multidisciplinary work.

2.8 Leadership for clinical governance, strategic oversight and monitoring of the provision of medical services was mostly good.

2.9 There was good collation and monitoring of performance data relating to custody, and most areas of performance were well understood and data were available. However, this was not comprehensive across all key activities, and there were deficits in the governance of the use of force in custody in particular.

2.10 The force did not always comply with the PACE code of practice for the detention, treatment and questioning of suspects (code C). Staff understanding and recording of the code G necessity test for arrest was also inconsistent. The mixed quality of entries in custody records did not reflect the overall good standard of care that we observed.

2.11 The force facilitated access to external scrutiny and had invited a peer review from another force. Gwent Police also had a healthy relationship with its independent custody visitors (ICV) scheme, which provided effective scrutiny. Learning from adverse incidents and near misses was also shared, and used to improve organisational understanding.

2.12 The force met its obligations under the public sector equality duty. Arrest information was recorded by nationality, age, gender and ethnicity, and senior managers regularly reviewed the data. However, there had been no equality impact assessments of local policies.

2.13 The force had a clear strategic focus on protecting and diverting vulnerable people from custody, but statutory partners did not always have sufficient capacity or capability to ensure that this priority led to improved outcomes for detainees. Despite multiagency work, too many people with mental ill health were still bought into custody as a place of safety because they were intoxicated, and consequently not accepted at a health-based place of safety.

2.14 There was effective monitoring of data on children in custody and clear engagement with partners, but too many children who were charged and had bail refused continued to be detained in custody overnight, where alternative local authority accommodation should have been provided.

2.15 There was an effective drug and alcohol arrest referral scheme to triage individuals with substance misuse issues.

Pre-custody: first point of contact

2.16 Frontline officers demonstrated a good understanding of individuals' vulnerability and how to take account of this in deciding what action to take. They also had access to some good specialist support in diverting people with mental ill heath away from custody. Officers could spend long periods with detainees when the health-based place of safety was full or waiting for ambulances, although this situation was improving.

2.17 A range of alternatives were used to avoid taking children into custody. Frontline officers knew that detention would be refused without robust justification, and where appropriate they used voluntary attendance and explored options such as community resolution.[5]

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

2.18 Custody staff treated detainees with respect. Vulnerability was identified quickly and recorded clearly. We observed positive interaction between custody staff and vulnerable detainees, and detainees we spoke to generally said they were treated well by staff.

2.19 Booking-in areas did not provide sufficient privacy for detainees to disclose sensitive or confidential information.

2.20 Custody staff were confident in their ability to identify and address most of the diverse needs of detainees, although women detainees were not routinely offered the opportunity to speak to a female member of staff while in detention. Provision for detainees with disabilities was also limited. Most staff could easily access professional telephone interpreting services for non-English speaking detainees, although not all the equipment for this worked effectively. Information on detainees' legal rights and entitlements was available in a range of languages, but not all staff knew how to access this. Hearing loops were available but not all staff knew how to use them.

2.21 Initial and ongoing risk assessments were comprehensive and focused appropriately on identifying and managing detainee risk. Appropriate levels of observations were set and mostly adhered to. There was good use of constant and close proximity observations. The standard of staff shift handovers was very good.

2.22 The routine removal of cords and laces from detainees' clothing was disproportionate to the risk they posed. Although not routine, the use of anti-rip clothing was also not always proportionate or used appropriately to manage and minimise risks. It was positive that all custody staff carried anti-ligature knives.

2.23 We observed instances when detainees were not given information about their legal rights and entitlements, and not all detainees were offered a legible or complete notice of their rights and entitlements. We also found many cases that had little rationale for why the detainee's detention had been authorised.

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[5] Voluntary attendance is used when suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention; community resolution involves informal agreement between the parties for the resolution of a less serious offence or antisocial behaviour incident.

2.24 The time that detainees arrived in custody was not always recorded accurately. Staff informed us that there could also be some excessive waits for detainees to be booked in. The force was unable to provide data about the length of time that immigration detainees spent in custody.

2.25 The voluntary attendance system was well embedded, with relatively high numbers of individuals involved.

2.26 PACE reviews were usually carried out in person and conducted appropriately. However, evidence from our case audits and case record analysis showed that they were often carried out too early and contained very little personal detail. Detainees were not routinely reminded when reviews had taken place while they were asleep.

2.27 The force had a bail policy but it was not comprehensive or effective. There was a mechanism to monitor individuals who had been released under investigation, but we were told this was not a priority. This indicated that not all detainees released under investigation received access to swift justice.

In the custody cell, safeguarding and health care

2.28 Conditions at both suites we inspected were generally good. Communal areas were clean and cells were in a decent condition, with very little graffiti. We discovered relatively few potential ligature points, although some remedial work was still needed.

2.29 The upgrade work at Newport had helped to improve the way in which detainees could be monitored. This had significantly increased staff confidence in feeling they could look after detainees safely.

2.30 Governance of the use of force in custody was not effective. Most staff were up to date with their operational safety training, but staff generally did not submit individual use of force forms to justify why they needed to use force against detainees.

2.31 In most cases we saw staff deal with challenging and vulnerable detainees in a patient and reassuring way. However, we identified some concerns and learning points in the cases that we reviewed, and we shared these with the force.

2.32 Positively, the number of strip searches of detainees was comparatively low and they were properly justified.

2.33 Detainees were given drinks and meals regularly and they could also be provided on request. Our analysis showed that few detainees were offered showers. We saw some detainees wearing paper suits or anti-rip clothing as an alternative to their own clothes that had been seized as evidence. This was inappropriate and suitable replacement clothing should have been provided.

2.34 Custody and frontline staff generally demonstrated a good understanding of safeguarding. However, we found little evidence that safeguarding concerns were addressed during the risk assessment process or followed up on release.

2.35 Our observations and case audit analysis showed a good focus on the care and welfare of children in custody. However, this was often not reflected in the custody records. Girls were not assigned a female officer to care for their welfare needs, and staff were not aware of this legal requirement.

2.36 While we were told that the appropriate adults scheme for vulnerable adults worked well, the arrangements for supporting children were inadequate and often involved long waits. The guidance leaflet for appropriate adults was not routinely given to them, and some custody staff were not aware of it.

2.37 Custody sergeants recognised the importance of minimising detention times for children and avoiding their overnight detention, and these cases were closely monitored. Despite this, our custody record analysis and case audits showed that a significant proportion of children detained remained in custody overnight.

2.38 Health services to detainees were delivered by skilled staff providing appropriate clinical assessment and treatment. Custody nurses felt supported and had access to training and professional development opportunities to maintain and enhance their clinical skills. Custody nurses now had 24-hour telephone access to a forensic medical examiner (FME) advisory service, but gaps in the local FME and sexual assault referral centre rotas resulted in a lack of available medical cover to attend the custody suite if required.

2.39 There was a systematic approach to clinical assessment and interventions were clinically appropriate. Clinical assessments were handwritten and generally of a good standard, with relevant information recorded on the custody record.

2.40 Medicines management had improved since our last inspection with the introduction of patient group directions, which allowed nurses to administer a comprehensive range of medicines without undue delay.

2.41 There were robust processes to ensure detainees could continue community-prescribed opiate substitution treatment in custody, subject to validation. The Gwent Drug and Alcohol Service provided a range of support to detainees with substance misuse issues. A needle exchange service had recently been established at Newport Central police station. Naloxone kits (to manage substance misuse overdose) and training were available, which was a positive initiative but this was not yet always provided to detainees on discharge.

2.42 There was an effective force-wide focus on mental health issues, with strategic partnerships between the police and mental health providers. A dedicated mental health practitioner based at HQ worked alongside staff in the control room, which was an excellent initiative and helped ensure that vulnerable people with mental health issues or in crisis received appropriate care. There was only one health-based place of safety in the force area and the custody suite was used too frequently as a place of safety under section 136 of the Mental Health Act 1983,[6] despite efforts by the force to decrease this. Mental health provision in custody was reasonable.

Release and transfer from custody

2.43 Recording of detainees' pre-release risk assessments was variable and often poor. As at the previous inspection, we were not confident that identified risks were always managed or sufficiently mitigated before release. Despite this, we did observe some good attention to ensuring that detainees were released safely.

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[6] Section 136 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.

2.44 Staff told us that the local court would generally accept detainees up to 2pm, and staff could cite examples of even later court cut-off times.

2.45 The quality of person escort records was mixed, and some did not convey sufficiently specific information about risk.

Areas of concern and recommendations

2.46 **Area of concern:** Governance and oversight of the use of force in custody was inadequate. Data were limited and unreliable, with insufficient information to demonstrate that when force was used this was both justified and proportionate.

Recommendation: The force should, with immediate effect, take measures to assure itself, and others, that all force used in the detention and custody of detainees is robustly scrutinised, and that each instance of use of force is justified and proportionate.

2.47 **Area of concern:** The overall quality of custody records was poor. There was an overreliance on standard scripts with little additional narrative to justify decisions and actions, and the force could not demonstrate the level of detainee care provided.

Recommendation: The force should ensure that all custody records are accurate and completed to a good standard, and that this is reinforced through quality assurance processes.

2.48 **Area of concern:** There were several procedures and practices that did not comply with PACE or code C of the codes of practice.

Recommendation: The force should ensure that all custody processes comply with code C of PACE. In particular, the force must, with immediate effect, ensure that notices setting out rights and entitlements are given to all detainees (code C section 3.2 a (i) (ii)).

2.49 **Area of concern:** Children charged and refused bail continued to be held in custody overnight with very few moved to alternative accommodation, despite robust monitoring.

Recommendation: The force should strengthen its joint working with local authority partners to ensure that children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight.

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 Gwent Police had a clear governance structure for custody. The criminal justice department, directed by the assistant chief constable (ACC), had overall responsibility for the custody function. This was supported by specialist staff trained to deliver custody services. This structure provided clear accountability for the safe delivery of custody.

3.2 There was generally sufficient custody staffing to deliver the service. However, our case audits and discussions with staff indicated some long waits between the arrival of detainees and their booking in and some long detention periods, which indicated that detainees were not always dealt with promptly. We also found that staff did not always adhere to detainee observation levels, with the reason for late checks recorded as due to 'staff shortages'. (See areas for improvement 5.24 and 5.34.)

3.3 The force had adopted the College of Policing's *Authorised Professional Practice – Detention and Custody*, complemented by some local policies to provide additional guidance. Staff were aware of the guidance and generally knowledgeable about processes and procedures. There was regular training to help all custody staff perform their roles, although not all policies and procedures were consistently followed in practice (see paragraphs 5.25, 5.39, 6.15, 6.31 and recommendation 2.48).

3.4 There was a strong strategic focus on the diversion of children and vulnerable adults away from custody and the criminal justice system. The strategy was underpinned by joint protocols with partners, including: health-based alternatives to custody for people with mental ill health; a protocol with local authority children's social care to reduce the prosecution of looked-after children; and a partnership with the youth offending service (YOS) to encourage restorative justice interventions and reduce offending and reoffending by young people.

3.5 Leadership in clinical governance, strategic oversight and monitoring of health services was generally good. Health care practitioners were fully integrated with the custody team and were involved in training of custody officers and custody detention officers (CDOs). This translated into effective operational working.

Accountability

3.6 The collation and monitoring of performance data on custody were generally good. Most areas of performance were well understood and data were available. However, this was not comprehensive across all key activities, with limited data on the use of force and detention times for immigration detainees. It was also not clear how the force used its performance data together with regular quality assurance measures to assess how well it was delivering different aspects of the custody service, identify trends and inform organisational learning.

3.7 The force did not have adequate mechanisms to assure itself, the Police and Crime Commissioner (PCC) and the public that the use of force in detention and custody was always safe and proportionate. The force was not in a position to provide the data required for the Home Office annual data return, as recommended by the National Police Chiefs Council. The data provided to us to enable an audit of use of force cases were inaccurate and unreliable. (See recommendation 2.46).

3.8 The force did not always comply with the Police and Criminal Evidence Act 1984 (PACE) and code C (code of practice for the detention, treatment and questioning of persons by police officers), which was a significant concern. Several procedural areas were not complied with (see paragraphs 5.39 and 6.15). In particular, we observed that not all detainees were informed of their rights and entitlements, and the written notices setting out those rights were incomplete. This was unacceptable and required immediate remedial action. (See recommendation 2.48.) The understanding and recording of the code G (statutory power of arrest) necessity test was inconsistent. We observed that officers were prompted rather than offering detail, and in some cases they were not asked to justify the necessity for arrest.

3.9 The overall quality of custody records was poor. There was an overreliance on the use of scripted drop-down menus with little additional narrative to provide context, and some key information was often missing. The records did not reflect the quality of care we observed during the inspection, but without adequate recording the force could not demonstrate how detainees had been dealt with or cared for while in custody. While there was a quality assurance process, it did not focus appropriately to ensure good quality record keeping. (See recommendation 2.47).

3.10 The force had an effective adverse incidents process. All incidents were reported to the force health and safety board and, where necessary, to the force professional standards department and the Independent Police Complaints Commission. Learning from adverse incidents and near misses was shared with staff, and used to improve organisational learning.

3.11 The force facilitated access to external scrutiny and was open to challenge; it had invited a peer review from another force and was using this to inform improvements. The force also had a healthy relationship with its independent custody visitors (ICV) scheme, which provided effective scrutiny, and welcomed and was receptive to ICV feedback.

3.12 The force could demonstrate that it was meeting its obligations under the public sector equality duty. There was a comprehensive joint strategic equality plan with the office of the PCC setting out the equality objectives for 2016/17. Specific custody areas were incorporated into the objectives, including proportionality of arrests, diverting people with mental ill health from custody, and children and young people. The equality and diversity board, chaired by the deputy chief constable, met quarterly to ensure delivery of the objectives.

3.13 Positively, arrest information was gathered by nationality, age, gender and ethnicity, and this was regularly reviewed by senior managers, with a particular focus on assessing any disproportionality. However, there had been no equality impact assessments of the local custody policies.

Partnerships

3.14 Although the force had a clear strategic focus on protecting and diverting vulnerable people and children from custody, supported by good strategic engagement, in operation, partners did not always have sufficient capacity to improve outcomes for detainees.

3.15 There was a multiagency protocol covering the use of section 136 of the Mental Health Act,[7] aimed at avoiding custody as a place of safety for people detained under the act, with its delivery overseen by a local multiagency monitoring group. However, there were still too many people with mental ill health bought into custody as a place of safety because they were intoxicated and consequently not accepted at a health-based place of safety until they were sober. The force was aware of this issue and had challenged relevant partners about their practices in refusing to take mentally ill people while they were intoxicated.

3.16 There were joint working arrangements to transfer children charged and refused bail to alternative local authority accommodation, supported by robust monitoring with partners. Despite this, most such children were detained in custody overnight because of a lack of alternative accommodation. (See recommendation 2.49.)

3.17 There were limited wider partnerships to divert vulnerable people and children away from custody by referring them to diversion schemes. However, since October 2015, there had been a pilot women's diversion scheme, in partnership with Women's Aid, in the Newport area. Women's Aid assessed women referred to them and set up support to prevent their reoffending and coming into the criminal justice system. To date, nearly 200 women had been referred to the scheme.

[7] 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.

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.

Assessment at first point of contact

4.1 Frontline officers showed a good understanding of vulnerability and the factors that might lead to an individual being vulnerable. The force has adopted the Association of Chief Police Officers, now the National Police Chiefs Council, definition of vulnerability, although not all staff were aware of this. However, they recognised issues such as age, mental health, alcohol and drugs misuse, social background and language as affecting an individual's vulnerability. All children were treated as vulnerable by virtue of their age, and officers were aware of their particular needs and their responsibility to identify safeguarding concerns. Officers said that training on a range of topics had helped them in their roles. They made decisions on assessing vulnerability on a case-by-case basis and were clearly confident in doing so.

4.2 Frontline officers generally received sufficient information from the call takers in the control room when responding to incidents. Information was provided on any warning markers about individuals, such as mental ill health, and although officers sometimes needed to ask for further details or checks, these were normally carried out quickly. Officers could also access a range of information through their hand-held devices, although this was sometimes hindered by mobile signal problems. They also had good local knowledge of offenders. Officers therefore had relevant intelligence to inform their decision making at the scene of an incident and in determining whether arrest was the most appropriate action.

4.3 There was some good support to help frontline officers avoid or divert people with mental ill heath away from custody. A mental health professional in the control room provided advice and assistance to help officers deal with incidents, and arranged access to mental health services or a health facility if needed. At the time of inspection, this service was not available full time across the force area, but officers who could access it reported a significant difference in how they were able to deal with individuals with mental ill health.

4.4 Decisions on an individual's mental capacity under the Mental Capacity Act 2015 were often made with health care professionals. Officers had had some training in this, but felt they needed professional support in deciding whether a person was capable of making their own decisions, and therefore the action they should take. The force lead officer for mental health also routinely became involved in cases to ensure that jointly agreed arrangements with mental health partners were adhered to. As a result of joint working with mental health services, officers were able to deal with some mentally ill individuals at the scene of the incident who otherwise might have been taken into custody.

4.5 Officers reported some long waits with detainees when the health-based place of safety was full or while waiting for ambulances, but generally felt the position had improved. Although individuals with mental ill health were detained under section 136 of the Mental Health Act[8]

[8] 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.

and taken to custody as a place of safety, this was only where they were refused access by the health-based place of safety because they were intoxicated and/or violent.

4.6 Frontline officers had a good focus on avoiding taking children into custody and explored a range of alternatives to divert them where possible. These included using community resolutions[9] and working with family members to find practical solutions to avoid arrest. Voluntary attendance[10] was used as a diversion from police custody, including for children. For the year to 30 June 2017, children made up 8% of custody throughput but 21% of all voluntary attendees. However, diversion schemes for children were only available after their arrest through the youth offending service, and there were no pre-custody schemes or options to divert them.

4.7 Arrangements for transporting detainees were based on a risk assessment that determined whether a police van needed to be called or whether officers could use their police car. There were no facilities for transporting detainees who were wheelchair users, although no officers we spoke to had experienced this situation. The force needed to formally specify how wheelchair users should be transported.

Area for improvement

4.8 Arrangements for transporting detainees in wheelchairs should be developed and published.

[9] The resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

[10] Where suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

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 Detainees generally received respectful treatment in the custody suites, and we saw mostly courteous interaction between custody staff and detainees from their first point of contact. Staff dealt with detainees sensitively during the booking-in process and built rapport with them to obtain important information about their vulnerability and identify any potential risk.

5.2 The booking-in areas in both Newport and Ystrad Mynach were not always sufficiently private for detainees to disclose important personal information confidentially. Not all the main booking-in desks had partitions, and so detainees could sometimes hear one another. Staff were aware of this and we did see them avoiding booking in detainees at the same time during quiet periods. At Ystrad Mynach, children were booked in at the one booking-in desk with a partition when it was available. We observed staff clearing the booking-in areas to carry out the risk assessment for two adult detainees who had committed serious and sensitive offences. Despite this, during busy periods too many detainees were booked in without enough privacy.

5.3 We observed a number of vulnerable and challenging detainees coming into the suites. Staff generally maintained a calm and patient approach, especially when speaking to vulnerable detainees. Staff explained the process with sufficient detail to detainees new to custody, and took extra time to book in children and detainees with mental health issues. The detainees we spoke to said that staff had treated them well and had also kept them informed of the progress of their cases.

5.4 At Ystrad Mynach, we were disappointed to see that items of clothing and shoes removed from detainees were placed outside their cells in evidence bags or on the floor. This was disrespectful and unnecessary, as there was storage available in the suite.

5.5 Arrangements for identifying and meeting diverse needs were reasonably good. Quarterly equality training for custody detention officers (CDOs) had covered diversity training in the last six months, including the particular needs of transgender detainees, mental health awareness and substance misuse. Generally, detainees were asked about their dietary requirements and any caring responsibilities shortly after their arrival, which allowed individual needs to be managed appropriately. A new process to identify detainees with learning difficulties during booking in was a positive initiative but it was too soon to assess its effectiveness.

5.6 Female detainees, including girls, were not allocated a woman member of staff to look after them or to speak to while in detention. For girls, this was a breach of section 31 of the Children and Young Persons Act 1933 (2008) (see paragraph 6.31 and area for improvement 6.35). Custody staff did not always offer women sanitary items, but we were assured that

they were searched only by female officers. There were no designated cells for female detainees in either suites.

5.7 There were some arrangements to meet the needs of people with physical or mobility difficulties, but neither suite fully complied with the Equality Act 2010. Ystrad Mynach had an adapted toilet in the health care facility, and at Newport there was one adapted shower. Both suites had a wheelchair, but none of the in-cell benches were suitable for detainees with poor or limited mobility. There were no extra thick mattresses available in either suite, although additional thin mattresses were provided to detainees who needed them.

5.8 Some staff were unable to locate religious artefacts stored in the suite. Those we found were not stored neatly or respectfully; in Ystrad Mynach, we found Bibles in the bedding store. There was not enough guidance to staff on the use or purpose of religious artefacts.

Areas for improvement

5.9 Booking-in desks should allow effective and private communication between custody staff and detainees. (Repeated recommendation 4.10)

5.10 Detainee clothing should be kept in an allocated safe storage place.

5.11 Female detainees, including girls, should be allocated a woman officer during their time in detention.

5.12 Detainees with disabilities should be catered for appropriately at both suites.

5.13 Religious artefacts should be stored neatly and respectfully, and staff should be able to locate them.

Communication

5.14 A professional telephone interpreting service was available to assist the booking in of non-English speakers, and staff were confident in how to access and use it. A double-handset telephone was available at Newport for this purpose but at Ystrad Mynach staff used either a speaker telephone or one handset that was noisy and lacked privacy, especially when the suite was busy.

5.15 There were no posters in any suite informing detainees of their right to free legal advice in a range of languages. Although legal rights and entitlements for detainees were available in 23 languages on the official government website, not all staff were aware of how to access the site and there were no printouts to assist booking in during busy periods (see paragraph 5.28). However, we did see one Polish detainee receiving a written copy of his rights and entitlements in his own language.

5.16 Hearing loops were available in both suites but not all staff were aware of their location or confident in how to use them. Legal rights and entitlements were available in easy-read and Braille formats, which was positive.

Areas for improvement

5.17 All suites should have double-handset telephones to facilitate telephone interpreting.

5.18 Custody staff should be aware of the location of hearing loops and trained in how to use them.

Risk assessments

5.19 There were some delays booking detainees in. A formal triage system had ceased in the previous month. Although we did not see either custody suite operating at a particularly busy time, some sergeants told us that they continued to prioritise vulnerable cases.

5.20 Standardised risk assessments were comprehensive and completed well. Custody sergeants and CDOs were properly focused on identifying risks, interacted well with detainees, and asked appropriate supplementary questions. There was routine cross-referencing to previous custody records on the local 'NICHE' custody computer system and police national computer (PNC) warning markers to inform risk assessments further.

5.21 Care plans set appropriate observation levels, which were reviewed regularly and dynamically when required. There was very good use of constant and close proximity level observations, which were appropriate in helping to manage and offset the risks posed by detainees assessed as requiring greater monitoring. Levels of observations were broadly adhered to, although a minority were logged as being late due to 'staffing shortages', which was unacceptable. Staff were competent in rousing intoxicated detainees and documented this well. Police officers on close proximity observations interacted well with detainees.

5.22 Custody staff routinely carried anti-ligature knives, which was positive. The routine removal of detainees' clothing with cords and laces was a disproportionate response to managing risk, particularly for the many assessed as low risk and with no history of suicide or self-harm. Positively, anti-rip clothing was not used routinely, although when it was used, this was not always justified – for example, when there was no history of using ligatures to self-harm or when the detainee was on close proximity observations.

5.23 The staff shift handovers we observed were very well conducted and involved all relevant staff, including health care professionals. They took place in private and focused appropriately on risk, detainee welfare and case progression. It was positive that a sergeant visited the detainees on completion of the handover.

Areas for improvement

5.24 Designated levels of observations should always be adhered to.

5.25 Detainees' clothing, including cords and laces, should only be removed on the basis of an individual risk assessment.

Individual legal rights

5.26 Custody sergeants' decisions to authorise detention were not consistently based on adequate information that justified why the arrest had been made and why detention was required. While officers we spoke to knew Police and Criminal Evidence Act 1984 (PACE)

code G which covers the statutory power of arrest (necessity test) and how to apply it, we observed some detainees being booked in without full explanations given by arresting officers or asked for by the custody sergeant. Custody sergeants said they would refuse detention if it could not be justified, and gave us some examples of this.

5.27 The force had made good use of voluntary attendance[11] as an alternative to custody, with a considerable increase in its use to 2,479 voluntary attendees in the year to 30 June 2017, a rise of 169% since the year to June 2015. The 18 police stations in the force area had facilities that allowed voluntary attendees to be interviewed outside the custody suite environment.

5.28 Not all detainees had their legal rights or entitlements explained to them when they were booked into custody, contrary to section 3.5a (i) (ii) of PACE. We also observed both in the suite and on CCTV footage that not all detainees were offered a written notice of their rights and entitlements. When they were, it was not always legible or complete. Similarly, not all detainees were offered a copy of the PACE codes of practice, and although the versions in the suites were up to date (2017) there were only a limited number. (See recommendation 2.48.)

5.29 A minority of detainees were not offered free legal representation on arrival (see above). However, when they were, they were told that if they declined, they could change their mind at any time. The arrangements for detainees to speak with their legal advisers by telephone were not private enough.

5.30 Our custody record analysis, case audits and discussions with staff indicated that there were some long waits for detainees before they were booked into custody. Force data showed an average waiting time of 33 minutes in the year to June 2017, but frontline officers told us that they could sometimes wait up to three or four hours, which was unacceptable particularly when this involved vulnerable detainees and those who remained in handcuffs (see paragraph 6.9). Our observations also showed that the time of arrival was not always accurately recorded on the custody record – in one example, a detainee who actually arrived at 12.23am was logged on the custody record as arriving at 12.35am. Such gaps had implications for the accuracy of custody records, and potentially meant that detainees spent longer in custody than was recorded. (See recommendation 2.47.)

5.31 Custody sergeants recognised the importance of minimising detention times, especially for vulnerable people and children, and we saw some evidence that such detainees were prioritised for booking in. However, our custody record analysis and case audits showed some long detention times while there were waits for appropriate adults (AAs) and/or legal advisers. Investigations were also not always progressed as quickly as possible due to lack of facilities such as interview rooms.

5.32 The force shared its Home Office Immigration Enforcement service arrangements with South Wales Police. Custody staff reported good relations with the Immigration Enforcement staff who attend the suites when immigration detainees were held in custody. Force data showed that 76 immigration detainees had been held in the year to 30 June 2017, which was a decrease of 63 since the previous year. The force was unable to provide data on the average time these detainees remained in police custody following service of an IS91[12] warrant of detention, making it difficult to assess how well the arrangements operated for immigration detainees being transferred to immigration removal centres (IRCs).

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[11] Where suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

[12] Served on an immigration detainee when there is no reasonable alternative course of action, such as if there is a likelihood they may abscond or their removal from the UK is imminent.

5.33 Arrangements for dealing with DNA samples were adequate.

Areas for improvement

5.34 Gwent Police should monitor detention times accurately to ensure that detainees are dealt with as promptly as possible and are released as soon as the need for detention no longer applies.

5.35 Custody sergeants should robustly apply PACE code G (the necessity test) to ensure that arresting officers provide full and clear explanations to justify the arrest to inform the decision to authorise detention.

5.36 Leaflets outlining detainee rights and entitlements should be legible and contain all relevant information.

5.37 There should be sufficient privacy for detainees to speak to their legal advisers by telephone.

PACE reviews

5.38 The PACE reviews of detention we observed were professional and caring, covering all aspects of detention. In addition to reminding detainees of their rights, they were asked about their welfare needs and were updated on the status of their investigation. Detainees were visited for reviews in their cells, and in one case in the exercise yard, and none were conducted through cell hatches, which was positive. However, our custody record analysis and case audits showed that reviews were often early, seemingly for the convenience of the inspectors rather than the benefit of detainees. In our custody record analysis, 31 of the 59 first reviews were early, as were 16 of the 32 second reviews where they were required. In the custody records we examined, there was little information about reviews and it was often unclear whether a detainee had been spoken to personally or had been asleep during their reviews. This was in stark contrast to the conduct of those we observed.

5.39 Detainees were not routinely reminded when a review had taken place while they were asleep, which did not comply with section 15.7 of PACE code C.[13] (See recommendation 2.48.)

5.40 Positively, we found few reviews conducted over the telephone, with only five in our custody record analysis.

Area for improvement

5.41 Where reviews of detention take place while a detainee is asleep, they should be informed of the review as soon as practicable, and this should be recorded on the custody record.

[13] A detainee who is asleep at a review, and whose continued detention is authorised, must be informed about the decision and reason as soon as practicable after waking.

Access to swift justice

5.42 Although the force had a bail policy, it was not comprehensive or effective. There was no start date for implementation and, although it provided guidance on prolific offenders, it did not provide timescales, such as minimum or maximum bail periods, that detainees should be granted pending the Crown Prosecution Service charging decision(s). The force had a dedicated sergeant for managing bail. Reminders were sent to officers and supervisors at least a week before a detainee was due to answer bail to ensure that enquiries had been progressed and avoid extending a detainee's bail unnecessarily.

5.43 Since the changes in the granting of pre-charge bail introduced under the Policing and Crime Act 2017, there had been a considerable reduction in the number of detainees bailed in these circumstances. We were told that the force had 614 detainees who were currently released under investigation – 24% of the 2,549 detainees taken into custody since 3 April 2017 when the act took effect – who had no obligation to return to police stations. As a result, significant numbers of detainees were increasingly released under investigation. When detainees are released under investigation they may not receive access to swift justice unless the force has effective processes in place to ensure that the resulting investigation is completed diligently and expeditiously, and that the detainee is informed of the outcome.

Area for improvement

5.44 The progress of investigations for detainees released under investigation should be monitored robustly to ensure there are no unnecessary delays and that cases are dealt with as quickly as possible.

Complaints

5.45 Posters with information for detainees about how to make a complaint were displayed in prominent areas of the custody suites, but in English and Welsh only.

5.46 We were told that the duty PACE inspector was responsible for noting any complaint that a detainee wished to make while they were in custody, but that if no PACE inspector was available, the detainee was advised to make their complaint once they had left the custody suite. There were no complaints noted in the custody records we examined. However, we observed one case where a detainee alleged excessive force that was not taken as a complaint, logged or subsequently investigated.

Area for improvement

5.47 All detainee complaints should be logged while they are in custody and investigated.

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 Since the previous inspection in 2012, the custody suite at Ystrad Mynach was no longer used full time but continued to be opened around once a month for short periods as additional accommodation for planned operations. During our inspection, Ystrad Mynach was opened for a longer period to allow for essential repair work at Newport Central, the principal site. As a result, we were able to assess the standard of the environment at both suites while they were occupied.

6.2 In general, conditions at both Newport and Ystrad Mynach continued to be good. There were efficient arrangements for carrying out regular checks of the cells, and the procedures for completing repairs worked well. Communal areas were clean, and although there were no handwashing facilities in the cells at Newport, cells were adequately equipped and kept in a decent condition, with very little graffiti. We found relatively few potential ligature points, although a hazard identified by the force in the sinks at Ystrad Mynach earlier in the year had not yet been addressed.

6.3 There had been considerable investment to improve the facilities at Newport. There was better CCTV coverage and life-signs monitoring equipment, which detected if a detainee was not showing signs of consciousness, now covered all cells. This upgrade had increased staff confidence in dealing with detainees safely. The cell call bell system at Newport had also been modernised and now allowed staff to talk to detainees, and detainees to receive telephone calls in their cell. This allowed effective two-way communication and was a significant improvement on what we found previously.

6.4 Custody staff were confident about what to do in the event of a fire. There had been a full fire evacuation at Newport within the previous month, and there were sufficient handcuffs in both suites for the process to be managed securely.

6.5 There was an appropriate range of emergency equipment in the suites, and apart from an oxygen cylinder at Newport, it was all in date. However, there was no clear audit trail to verify that the emergency equipment was routinely checked and monitored (see paragraph 6.45).

Safety: use of force

6.6 Oversight and governance of use of force in custody were inadequate. It was concerning that there was no reliable or accurate data on the use of force in custody (see also paragraph 3.7 and recommendation 2.46). Most staff were up to date with their operational safety training (OST). However, the OST instructors told us that they had not received continuous

professional development refresher training to support their accreditation since 2009. Despite appropriate focus in the training, few staff submitted individual use of force forms to justify why they had used force on detainees in custody. We were given only one use of force form for the 10 incidents we reviewed; this was unacceptable. Compounding this problem further, some detention logs did not contain sufficient, if any, information to justify why force had been used in custody.

6.7 Operational safety training placed good focus on de-escalating situations. We found no use of Taser, PAVA or batons in the previous six months. We observed custody staff dealing patiently with some challenging and vulnerable detainees. They generally only used force as a last resort and following negotiations with detainees, which was positive.

6.8 CCTV footage was only retained for 31 days. Through our observations, conversations with staff, limited data provided by the force and custody record analysis we were able to identify 10 cases where force had been used in custody (nine during the previous 31 days and one that had been referred to professional standards following a complaint), which we reviewed in depth, including cross-referencing them against CCTV footage. Only around a third of the incidents we reviewed were managed well overall, and we found at least learning points in the remainder. We had serious concerns in one case, which we referred back to the force for review and action as appropriate. Concerns from the CCTV footage included: force used was not always proportionate to the risk; some poor techniques that were potentially injurious to the detainee; some unprofessional practice; and a failure to maintain the dignity of a detainee.

6.9 Many detainees arrived in custody wearing handcuffs. There was some confusion among arresting officers and custody sergeants about who could authorise the removal of handcuffs, and local policy was not always followed. As a consequence, we saw some cases where handcuffs remained in place on compliant detainees for too long – for almost an hour in one case we viewed on CCTV. This was disproportionate to the threat posed in the controlled custody environment.

6.10 Force data showed that in the year to end of June 2017, 4% of detainees had been strip searched in custody, which was reasonably low. We saw few strip searches authorised during the inspection. The rationale to justify these was sufficient, and the records we examined indicated the specific grounds and justification for the strip search, which was appropriate.

Area for improvement – national issue

6.11 All operational safety training instructors should receive regular refresher training to ensure their continuing professional competence and accreditation in providing operational safety training.

Detainee care

6.12 Food and drinks were served to detainees at designated mealtimes and they could also be requested outside these hours. Although we observed that food and drinks were given to detainees regularly throughout the day, the custody records we inspected did not always accurately reflect when meals were served. (See recommendation 2.46.) There was a wide range of low calorific microwave meals available at Newport, but at Ystrad Mynach stocks were low with only a limited range of four meals available. In our custody record analysis, 78% of detainees held under 24 hours were offered a meal while detained. Kitchens were clean and well equipped.

6.13 In our custody record analysis, only 8% of detainees who stayed in the suite for less than 24 hours were offered a shower, while 46% held over 24 hours were offered one. During our inspection, five detainees at Ystrad Mynach were not offered a shower before attending court in the morning having stayed overnight in the suite, and staff could not locate any clean towels in the stores at our request. The shower in Newport had adequate privacy, but at Ystrad Mynach only one of the three showers was functioning. Staff supervision was required when this facility was in use due to some potential ligature points (see paragraph 6.2).

6.14 Despite the high numbers of children coming into custody, there was no protocol to allow visits from family members to children or vulnerable detainees in either suite. Custody detention officers (CDOs) were unaware if visits from family members not acting as appropriate adults could be permitted or facilitated.

6.15 We saw four detainees at Ystrad Mynach returning from interview wearing paper suits or anti-rip clothing as an alternative to their own clothes. Suitable replacement clothing should always be provided to detainees in accordance with the Police and Criminal Evidence Act (PACE code C section 8.5f).

6.16 There was a limited stock of reading material at Ystrad Mynach and neither suite provided any books for children or non-English speaking detainees. Reading materials were not routinely offered to detainees before they were placed in a cell and were usually only issued following detainee request. Our custody record analysis showed that only 3% of detainees held for less than 24 hours were offered reading material.

6.17 Soap and toilet paper were only issued to detainees on request, but not all detainees were informed of this by custody staff before they were locked in a cell. There was a good supply and suitable range of women's sanitary packs and toiletries for detainees in both suites, but again they were only provided on request.

Areas for improvement

6.18 **All detainees held overnight should be offered a shower.** (Repeated recommendation 4.48)

6.19 **Visits by family members to children and vulnerable detainees should be facilitated.**

6.20 **Detainees should always be given suitable replacement clothing when their own clothes are removed.**

6.21 **Detainees should have ready access to toiletries, handwashing facilities and toilet paper, as well as a suitable range of reading materials.**

Safeguarding

6.22 Frontline and custody officers generally had a good understanding of safeguarding and their responsibilities for this. There had been training on aspects of safeguarding, such as child sexual exploitation, and flags on the force IT system clearly alerted officers to any concerns. However, our case audits showed that specific concerns, even though flagged on the system (such as a child in detention who was on the child protection register), did not always inform the risk assessments while in custody or on release, which meant that some safeguarding issues could be missed.

6.23 Responsibility for safeguarding referrals rested primarily with arresting or investigating officers. The staff we spoke to knew how and when they should make referrals for vulnerable adults and children. However, few referrals were recorded on custody records, and although custody sergeants could check that these had been made, there was no system to assure that this always happened.

6.24 Children and vulnerable adults did not always receive early and effective support from an appropriate adult (AA). Parents or other relatives were contacted in the first instance, often at the time of arrest where possible. When a family member was not appropriate because they had been involved in the incident or were unwilling to attend, custody sergeants sought independent AAs.

6.25 The independent service for vulnerable adults, which included 17 year olds, was provided by an agency under a contract and was reported to work well, with AAs arriving promptly and available at any time.

6.26 Under a joint protocol covering children, custody sergeants contacted the youth offending service or local authority children's social care services. AAs were expected to attend as soon as possible so that the child's rights and entitlements could be read to them in the AA's presence and explained. However, AAs for children were not available overnight, and we were told there could be long delays during the daytime. In practice, most AAs arrived for the interview stage, rather than the reading of rights and entitlements. Our custody record analysis showed that the average time a child waited for an AA to arrive was just under 10 hours, and in some cases much longer. Record keeping for request and arrival times and the relationship of the AA to the detainee was generally poor, making it difficult to assess the overall position, or where specific delays occurred. However, our case audits and discussions with staff indicated that children were detained longer than needed, including overnight, while waiting for an AA to arrive. This was a poor outcome for these children.

6.27 The guidance leaflet to help AAs understand their role and responsibilities – particularly important for family members who may not have acted in this capacity before – was not routinely given to them, and some custody staff were not aware of it.

6.28 There was a good focus on the care of children while in custody, supported by guidance for officers. We observed positive interactions between custody staff and children. Children were prioritised for booking in, and were kept away from adult detainees where possible. Staff paid good attention to identifying any health concerns, and all children were referred to the health care practitioner for assessment and to inform the care plan. There were no designated cells for children but custody sergeants could use the cells closest to the booking-in desks to offer more reassurance.

6.29 Although most reviews of detention seemed to be in person, it was not clear from custody records whether the child was spoken with, or whether care needs – such as exercise, showers and the provision of reading materials – had been met. Girls were not assigned a female officer to care for their welfare needs as required by the Children and Young Person's Act 1933 (see also paragraph 5.6), and staff we spoke to were not aware of this requirement, even though it was also reinforced in the force's own guidance note on children and young people in police detention.

6.30 Custody sergeants recognised the importance of minimising the time children spent in custody. They were confident in refusing detention for children and provided examples of this. There was guidance and training to support custody sergeants in seeking alternative accommodation for children to avoid their detention overnight.

6.31 There was detailed monitoring with partner agencies at the Gwent monitoring and review panel of individual cases of children detained overnight, both before and after charge. The

panel examined whether the correct actions had been taken in each case and, in particular, whether detention overnight could have been avoided, especially where the local authority should have provided alternative accommodation. There was further oversight by the local safeguarding children's board, the criminal justice strategy board and the Welsh government. However, the force did not routinely monitor the total number of children detained overnight so was unable to demonstrate the impact of its actions and whether the number had reduced. Despite the robust scrutiny process, and the statutory requirement on local authorities to arrange alternative accommodation for children who are charged and refused bail, a significant proportion of children continued to be detained overnight.

6.32 Force data showed that of the 43 children charged and refused bail in the year to 30 June 2017, 30 requests for accommodation were made, but only five were moved to alternative non-secure accommodation and none to secure accommodation. There were protocols with local authority partners, including escalation procedures when accommodation was not available. However, the lack of both secure and non-secure accommodation meant that children remained in police cells overnight, which was unacceptable. (See recommendation 2.49.)

Areas for improvement

6.33 The force should strengthen custody safeguarding arrangements by ensuring that all necessary referrals are made and that concerns about detainees are addressed adequately during and when leaving custody.

6.34 The force should meet the legal requirement to assign a woman officer to be responsible for the welfare needs of all girls held in custody.

6.35 The force should improve outcomes for children and vulnerable adults by ensuring early support from appropriate adults, who should be available at all times, and the force should actively monitor the effectiveness of its arrangements, based on accurate recording in custody records.

Governance of health care

6.36 Directly employed custody nurses provided one nurse to each shift team of police officers. The nursing workforce had been understaffed but nurses were now in post, with further recruitment to provide two nurses per shift planned from September 2017. Gaps in the rota were covered by three experienced regular agency nurses who felt part of the team and had received the same training as permanent staff. The lead nurse provided effective operational and clinical leadership and had also covered shifts. When a regular nurse was not available to cover a shift, a forensic medical officer (FME) from a locum agency sometimes attended for the whole 12-hour shift.

6.37 There was a good range of strategic health meetings that the force attended, including a mental health and learning disability partnership board, governance meetings and drug and alcohol contract review meetings.

6.38 Custody nurses were now based at Newport Central custody suite and only attended Ystrad Mynach at very busy periods when it was opened as an overspill facility. This had eased the pressure on custody nurses and reduced waiting times.

6.39 There was 24-hour telephone access to a FME advisory service, which was positive. The force also operated a local retained FME contract and a sexual assault referral centre (SARC)

rota but both had gaps resulting in a lack of availability of medical cover to attend the custody suite if required. This had occasionally led to detainees being sent to hospital or, if a SARC assessment was required, to the SARC at Bristol.

6.40 There were no agreed response times linked to forensic or clinical priorities, although the effect of this was partly offset by the small number of suites, effective clinical leadership and mostly appropriate staffing levels. However, in our custody records analysis, the shortest waiting time to see a health care professional was three minutes with the longest at 15 hours 42 minutes; the mean was three hours 42 minutes, which was too long.

6.41 New staff completed a comprehensive three-day induction and were supervised by an experienced custody nurse until competent to undertake a shift unaccompanied. There were very good training and professional development opportunities to maintain and enhance custody nurses' clinical skills. There were systems to monitor health professionals' credentials and revalidation. Custody nurses felt supported and discussed clinical issues, but managerial and clinical supervision was not formalised.

6.42 The police complaint system was used for health care complaints and was insufficiently confidential. However, lessons learned from complaints and significant incidents were shared with the team and informed service delivery.

6.43 Both suites had medical rooms that were clean, and separate rooms for forensic sampling, which complied with infection prevention standards. However, the medical fridges at both suites lacked appropriate temperature monitoring and it was unclear if they were at the correct temperature for storing medication.

6.44 All custody nurses had received intermediate life support training. Custody staff received basic life support training and had access to automated external defibrillators. Emergency equipment was appropriate and in date, apart from one oxygen cylinder at Newport, and the content of one first aid kit at Ystrad Mynach had not been checked recently. The audit trail to verify if equipment was routinely checked and maintained was insufficient.

Areas for improvement

6.45 Health care professionals should see detainees consistently within agreed response times that are linked to forensic and clinical priorities.

6.46 Detainees should be able to complain about health services through a well-advertised and confidential health complaints system.

6.47 Routine checking and maintenance of emergency equipment and medicine fridges should be fully documented and regularly audited.

Patient care

6.48 The custody sergeant referred detainees to custody nurses based on need or at a detainee's request. Custody nurses received an electronic handover from their nursing colleague at the start of each shift and attended the force's shift handover. They also triaged detainees in the holding cell and prioritised them based on clinical need and vulnerability, including children, which was positive.

6.49 The consultations we observed were professional and caring. The door was closed depending on a risk assessment. Telephone interpreting services were available for non-

English speaking detainees when required. Clinical assessments were handwritten and the ones we reviewed were of a good standard and stored appropriately. Relevant information was recorded on the custody record.

6.50 Detainees could continue prescribed medication, including opiate substitution therapy, in custody and police attempted to collect prescribed medications from detainees' homes, GPs and community pharmacies. Symptomatic relief was provided for detainees withdrawing from drugs or alcohol where clinically indicated.

6.51 Standardised stock medication was well organised, checked regularly, within its expiry date and stored securely. Key security was appropriate for the medicine cabinets in the clinical rooms at both suites. However, the medicine cabinet for officers to access some stock medication at Ystrad Mynach also contained an out-of-date bottle of methadone brought in by a detainee, which was awaiting destruction. The keys were readily available in the door and stored in an open key cupboard, which lacked the appropriate security for a controlled drug.

6.52 The introduction of a comprehensive range of patient group directions supported the custody nurses to provide medication promptly to detainees without having to contact an FME for certain medicines. Detainees also had access to nicotine replacement therapy.

Area for improvement

6.53 Medicines for destruction should be stored separately to stock medication and with the appropriate security.

Substance misuse

6.54 Gwent Drug and Alcohol Service (GDAS) had been commissioned by Gwent substance misuse area planning board since April 2015 to provide an integrated drug, alcohol and family support service across Gwent, including within the criminal justice sector. It was provided by a consortium of three organisations - Kaleidoscope, Drugaid and G4S.

6.55 Gwent Integrated Recovery Intervention Service (IRIS) provided a dedicated team working alongside criminal justice agencies. An arrest referral worker attended the custody suite daily, including weekends and bank holidays, and visited local courts. They offered assessment, brief intervention work, information, signposting and onward referral to services providing clinical treatment, psychosocial support and other confidential services in the community. Children were signposted or directly referred to age-appropriate services.

6.56 Out of hours, the police obtained the detainee's consent to refer them to the service and they were seen the following day or followed up in the community if they were released before they were seen. Relevant information was recorded on the custody record and GDAS staff had access to community records.

6.57 Harm reduction services had improved since the last inspection with the recent implementation of needle exchange at the Newport suite and safer injecting advice, which was positive. Custody nurses and GDAS and IRIS staff had also worked with Public Health Wales to roll out naloxone kits (a drug to reverse opiate overdose) and overdose awareness training to detainees leaving police custody. The first kit issued in Gwent was in June 2016 and was the first provided from a custody suite in England and Wales. Between June 2016 and the end of March 2017, 50 kits had been issued to detainees. Although this was commendable, the kits were not always given to all who required them (see paragraph 7.2).

Mental health

6.58 There were good strategic partnerships between the police and the local Aneurin Bevan University Health Board, which provided mental health services. There was a crisis care concordat and its implementation was monitored by relevant parties. Police custody staff received mental health awareness training.

6.59 The criminal justice liaison team based at Newport magistrates' court provided mental health advice between 9am and 5pm on weekdays and attended custody if required. Custody nurses also contacted mental health staff at St Cadoc's Hospital in Caerleon, Newport and community teams who could access information about the detainee if they were known to mental health services. Police did not have data on the number of detainees arrested and referred for a Mental Health Act assessment or the average wait. However, custody staff reported that waiting times were mostly reasonable, with some exceptions.

6.60 The force had made a decision not to record data on the use of section 136 of the Mental Health Act[14] where the person was conveyed directly to the health-based place of safety (HBPOS) at St Cadoc's Hospital or to A&E. This decision had recently been rescinded, and between April and the end of June 2017 there had been 68 recorded detentions under section 136 – 50 (75%) had been at the HBPOS, two (3%) at A&E and 15 (22%) at Newport central police station. The custody suite was used too frequently as a place of safety under section 136, despite efforts by the force to decrease this. Some custody records noted that health staff at the HBPOS had breathalysed individuals and would not accept them if they were 'over the limit'. We were informed that this practice had recently ceased.

6.61 There was a dedicated mental health practitioner based at force headquarters who worked alongside staff in the control room. This was an excellent initiate to ensure vulnerable people with mental health issues or in crisis received appropriate care. This pilot had been successful and was being extended to have a mental health practitioner on each shift and a team leader.

6.62 The multi-agency procedure in the force for sections 135 and 136 of the Mental Health Act was out of date (October 2010) and needed updating.

Areas for improvement

6.63 The force should monitor the number of detainees arrested and referred for a Mental Health Act assessment and the response times to evaluate the effectiveness of the provision for the care and welfare of detainees.

6.64 People detained under section 136 of the Mental Health Act should only be held in police custody as a place of safety in exceptional circumstances, and the multiagency procedure should be updated.

[14] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved Mental Health Practitioner, and for the making of any necessary arrangements for treatment or care.

Good practice

6.65 *The presence of a mental health practitioner at force headquarters working alongside staff in the control room ensured vulnerable people with mental health issues or in crisis received appropriate care.*

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 and custody record analysis, the recording of pre-release risk assessments was mostly poor. Although there was a comprehensive template on the force NICHE IT system, records generally contained little indication that risks were routinely addressed. It was often unclear how detainees were getting home. However, and despite a notable exception viewed on CCTV footage, our observations indicated that the working practice was generally better than what was recorded.

7.2 Custody sergeants were properly focused on ensuring a safe release for detainees, and were aware of the specific offences and circumstances that made them more at risk on release. Detainees at risk of suicide or self-harm or those involved in sexual offence cases generally received additional support from health care professionals before release. A needle exchange and naloxone (to reverse opiate overdose) were available for detainees with identified substance issues (see paragraph 6.57), but these were not routinely given to all detainees who might have benefited from them. All detainees were asked about their means to get home, but there was no petty cash or travel warrants to assist them. Officers took many detainees home, particularly if they were vulnerable, which was positive.

7.3 The force had a generic support leaflet listing some useful telephone numbers, but this was not routinely given to all detainees on their release.

Area for improvement

7.4 Arrangements made for the safe release of detainees should be properly recorded and should ensure that risks have been addressed.

Courts

7.5 Custody staff told us that the local magistrates' court would generally accept detainees until 2pm, which was positive, and there were many examples when detainees had been accepted later than this. We found no evidence that detainees spent longer in custody than necessary because they were not accepted by the first available court.

7.6 The information in the person escort records (PERs) we examined was variable. Many did not include specific information to allow effective ongoing management of risk. Risks were not always explained verbally to escorting officers, and we saw one case where the officers did not review the PER before they transported the detainee to court.

Area for improvement

7.7 Person escort records should include all the specific information concerning the detainee's known risks.

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

Areas of concern and recommendations

8.1 **Area of concern:** Governance and oversight of the use of force in custody was inadequate. Data were limited and unreliable, with insufficient information to demonstrate that when force was used this was both justified and proportionate.

Recommendation: The force should, with immediate effect, take measures to assure itself, and others, that all force used in the detention and custody of detainees is robustly scrutinised, and that each instance of use of force is justified and proportionate. (2.46)

8.2 **Area of concern:** The overall quality of custody records was poor. There was an overreliance on standard scripts with little additional narrative to justify decisions and actions, and the force could not demonstrate the level of detainee care provided.

Recommendation: The force should ensure that all custody records are accurate and completed to a good standard, and that this is reinforced through quality assurance processes. (2.47)

8.3 **Area of concern:** There were several procedures and practices that did not comply with PACE or code C of the codes of practice.

Recommendation: The force should ensure that all custody processes comply with code C of PACE. In particular, the force must, with immediate effect, ensure that notices setting out rights and entitlements are given to all detainees (code C section 3.2 a (i) (ii)). (2.48)

8.4 **Area of concern:** Children charged and refused bail continued to be held in custody overnight with very few moved to alternative accommodation, despite robust monitoring.

Recommendation: The force should strengthen its joint working with local authority partners to ensure that children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight. (2.49)

Areas for improvement

Pre-custody: first point of contact

8.5 Arrangements for transporting detainees in wheelchairs should be developed and published. (4.8)

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

8.6 Booking-in desks should allow effective and private communication between custody staff and detainees. (5.9, repeated recommendation 4.10)

8.7 Detainee clothing should be kept in an allocated safe storage place. (5.10)

8.8 Female detainees, including girls, should be allocated a woman officer during their time in detention. (5.11)

8.9 Detainees with disabilities should be catered for appropriately at both suites. (5.12)

8.10 Religious artefacts should be stored neatly and respectfully, and staff should be able to locate them. (5.13)

8.11 All suites should have double-handset telephones to facilitate telephone interpreting. (5.17)

8.12 Custody staff should be aware of the location of hearing loops and trained in how to use them. (5.18)

8.13 Designated levels of observations should always be adhered to. (5.24)

8.14 Detainees' clothing, including cords and laces, should only be removed on the basis of an individual risk assessment. (5.25)

8.15 Gwent Police should monitor detention times accurately to ensure that detainees are dealt with as promptly as possible and are released as soon as the need for detention no longer applies. (5.34)

8.16 Custody sergeants should robustly apply PACE code G (the necessity test) to ensure that arresting officers provide full and clear explanations to justify the arrest to inform the decision to authorise detention. (5.35)

8.17 Leaflets outlining detainee rights and entitlements should be legible and contain all relevant information. (5.36)

8.18 There should be sufficient privacy for detainees to speak to their legal advisers by telephone. (5.37)

8.19 Where reviews of detention take place while a detainee is asleep, they should be informed of the review as soon as practicable, and this should be recorded on the custody record. (5.41)

8.20 The progress of investigations for detainees released under investigation should be monitored robustly to ensure there are no unnecessary delays and that cases are dealt with as quickly as possible. (5.44)

8.21 All detainee complaints should be logged while they are in custody and investigated. (5.47)

In the custody cell, safeguarding and health care

8.22 All operational safety training instructors should receive regular refresher training to ensure their continuing professional competence and accreditation in providing operational safety training. (6.11)

8.23 All detainees held overnight should be offered a shower. (6.18, repeated recommendation 4.48)

8.24 Visits by family members to children and vulnerable detainees should be facilitated. (6.19)

8.25 Detainees should always be given suitable replacement clothing when their own clothes are removed. (6.20)

8.26 Detainees should have ready access to toiletries, handwashing facilities and toilet paper, as well as a suitable range of reading materials. (6.21)

8.27 The force should strengthen custody safeguarding arrangements by ensuring that all necessary referrals are made and that concerns about detainees are addressed adequately during and when leaving custody. (6.33)

8.28 The force should meet the legal requirement to assign a woman officer to be responsible for the welfare needs of all girls held in custody. (6.34)

8.29 The force should improve outcomes for children and vulnerable adults by ensuring early support from appropriate adults, who should be available at all times, and the force should actively monitor the effectiveness of its arrangements, based on accurate recording in custody records. (6.35)

8.30 Health care professionals should see detainees consistently within agreed response times that are linked to forensic and clinical priorities. (6.45)

8.31 Detainees should be able to complain about health services through a well-advertised and confidential health complaints system. (6.46)

8.32 Routine checking and maintenance of emergency equipment and medicine fridges should be fully documented and regularly audited. (6.47)

8.33 Medicines for destruction should be stored separately to stock medication and with the appropriate security. (6.53)

8.34 The force should monitor the number of detainees arrested and referred for a Mental Health Act assessment and the response times to evaluate the effectiveness of the provision for the care and welfare of detainees. (6.63)

8.35 People detained under section 136 of the Mental Health Act should only be held in police custody as a place of safety in exceptional circumstances, and the multiagency procedure should be updated. (6.64)

Release and transfer from custody

8.36 Arrangements made for the safe release of detainees should be properly recorded and should ensure that risks have been addressed. (7.4)

8.37 Person escort records should include all the specific information concerning the detainee's known risks. (7.7)

Good practice

8.38 The presence of a mental health practitioner at force headquarters working alongside staff in the control room ensured vulnerable people with mental health issues or in crisis received appropriate care. (6.65)

Section 9. Appendices

Appendix I: Inspection team

Ian Macfadyen	HMI Prisons team leader
Maneer Afsar	HMI Prisons team leader – observer
Fionnuala Gordon	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Norma Collicott	HMICFRS inspection lead
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMICFRS inspection officer
Maureen Jamieson	HMI Prisons health services inspector
Anna Fenton	HMI Prisons researcher
Joe Simmonds	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.

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.

Recommendation

The force should cross reference custody record dip sampling to CCTV checking and monitor handovers as part of its quality assurance regime. (3.17)
Partially 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 recommendation

Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to manage and mitigate the risks. (2.24)
Not achieved

Recommendations

Booking-in desks should allow effective and private communication between custody staff and detainees. (4.10)
Not achieved (repeated as area for improvement 5.9)

Handovers should be comprehensive and attended by detention officers and police custody staff. (4.22)
Achieved

Gwent police service should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance. (4.29)
Not achieved

Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.37)
Partially achieved

All detainees held overnight should be offered a shower. (4.48)
Not achieved (repeated as area for improvement 6.18)

Replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed. (4.49)
Not achieved

Individual rights

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

National issue

Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given. (2.25)
Not achieved

Recommendations

Gwent Police should further develop and promote alternative-to-custody approaches and custody officers should ensure that the 'necessity test' for arrest is properly used. (5.8)
Not achieved

Gwent Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.9)
Partially achieved

A two-way telephone handset should be provided to aid interpretation. (5.10)
Partially achieved

The force should liaise with the courts managers to ensure that court cut-off times are suitably flexible. (5.20)
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

There should be a forensic medical examiner on call at all times, who should ensure that correct prescribing practice is followed. (2.23)
Achieved

Recommendations

If at any time a health professional is not available to attend a suite, this should be reported as a 'near-miss' incident, in accordance with force policy. (6.7)
Achieved

Clinical governance arrangements should include all health professionals. (6.8)
Achieved

All clinical records should be stored in line with the Data Protection Act and Caldicott guidelines. (6.16)
Achieved

All medications should be administered against a patient group direction or prescription that meets the standards of professional bodies. (6.17)
Achieved

Detainees should be able to continue any prescribed course of medication while in custody. (6.18)
Achieved

All detainees should be offered the services of a drugs/alcohol worker. (6.23)
Achieved

Police custody should not be used as a place of safety for section 136 Mental Health Act assessments. (6.31)
Not achieved

All police officers should receive regular refresher training on mental health issues. (6.32)
Achieved