Report on an unannounced inspection visit to police custody suites in

Dyfed-Powys

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary and Fire & Rescue Services

6–17 November 2017

Glossary of terms

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

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Clive House, 5th floor, 70 Petty France, London, SW1H 9EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk or HM Inspectorate of Constabulary and Fire & Rescue Services at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or contact@hmic.gsi.gov.uk.

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/ or https://www.justiceinspectorates.gov.uk/hmicfrs/

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Contents

Contents

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 Dyfed-Powys Police custody in 2013, and overall we found that progress since then to improve custody services was mixed. Management of the service had been strengthened and the good interactions with detainees maintained. However, concerns remained about staffing, with continued reliance on frontline police officers to deliver custody services.

A number of positive features were evident during this inspection. Officers had a good understanding of vulnerability and this was embedded as a way of working. The force's approach to children remained particularly strong, diverting them away from custody as much as possible and keeping any time they spent in custody to a minimum. Detainees were generally treated respectfully and received a good level of care while in custody.

However, there were a number of areas where we had concerns. The force was not complying with some of the requirements under Code C of the Police and Criminal Evidence Act 1984 (PACE) for the detention, treatment and questioning of suspects. Information to manage performance was not comprehensive and some of it was inaccurate, including the use of force in custody.

There was an over-reliance on removing detainees' own clothing and replacing this with anti-rip clothing as a means of managing risk, rather than considering other options such as enhanced observation levels. Despite some good partnership arrangements with mental health services, waiting times for mental health assessments for individuals detained in custody were too long.

We found a strong culture across the force to support the safe delivery of custody. The force was clearly committed to improving and we are confident that it will use our findings and recommendations to help deliver improvements to custody services.

We noted that of the 30 recommendations made in our previous report after our inspection of 2013, 10 recommendations had been achieved, 14 had been partially achieved and six had not been achieved.

This report provides five recommendations to the force (and the Police and Crime Commissioner) and highlights 28 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

January 2018

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 and HM Inspectorate of Constabulary and Fire & Rescue Services. 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*[1] 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.[2] 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.[3] A total sample of 89 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 Dyfed Powys police custody; the first inspection was from 11 to 18 June 2013. During the 2017 inspection, the designated cells and cell capacity in the force area were as follows:

---

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

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

3 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 cells	Cell capacity
Aberystwyth	9
Ammanford	8
Brecon	9
Cardigan (contingency)	6
Haverfordwest	20
Llanelli (contingency)	10
Newtown	10

2.6 Cardigan and Llanelli were contingency suites, used occasionally to meet demand.

Leadership, accountability and partnerships

2.7 Under the direction of the Assistant Chief Constable, a clear governance structure provided accountability for the safe delivery of custody in Dyfed-Powys. Internal meeting structures to oversee custody were effective. Regular meetings monitored the contract requirements and performance of external providers.

2.8 Staffing of custody suites was not always adequate and frontline officers were sometimes relied on to deliver custody services. On occasions, inadequate staffing led to unsafe detention practices.

2.9 Training and shadowing opportunities prepared staff well to deliver custody services. The force had adopted authorised professional practice (APP) for custody as set by the College of Policing. Working practices across the force were inconsistent, some were not consistent with APP and local policies were out of date.

2.10 The collation and monitoring of performance information on custody were inadequate. The force used a bespoke custody application but limitations in the software prevented the force from providing some data. Other performance data were unreliable and, in some cases, inaccurate. This prevented the force from monitoring performance effectively.

2.11 As recommended by the National Police Chiefs Council and in line with Home Office annual return requirements, data concerning the use of force in custody were collated, but these were inaccurate and unreliable. Mechanisms to reassure the force itself, the Police and Crime Commissioner and the public that the use of force in custody was safe and proportionate, were inadequate.

2.12 The force did not always comply with a number of significant areas of Code C of the PACE Codes of Practice for the detention, treatment and questioning of suspects. This was a serious concern that we expected the force to address immediately.

2.13 The force was generally meeting its commitment to the public sector equality duty. However, lack of accurate data prevented them from identifying and monitoring effectively areas of potentially disproportionate treatment for detainees in custody.

2.14 The force had a clear focus on protecting and diverting vulnerable people from custody. They engaged well with partners but partners did not always have sufficient capacity and capability to meet their responsibilities which meant that outcomes for some detainees were poor.

2.15 Custody was used infrequently as a place of safety under Section 136 of the Mental Health Act[4] (MHA). However, on the 10 occasions it had been used in the previous 12 months, this did not provide good care in the most suitable environment for individuals in crisis. Those arrested for an offence who subsequently required an MHA assessment in custody were often held for too long while waiting for this, often as a result of delays in attendance by partner agencies.

Pre-custody: first point of contact

2.16 Frontline officers understood and took account of vulnerability when deciding how to deal with incidents, and generally received good information from the call centre to help them make decisions. They were properly focused on diverting vulnerable people and children from custody.

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

2.17 During routine interactions, custody staff treated detainees with respect. However, some practices were disrespectful, including limited privacy in booking-in areas and the failure to provide replacement footwear consistently.

2.18 Custody staff identified and addressed confidently most of the diverse needs of detainees in their care. Religious materials were available and most detainees could observe their faith. However, there were some weaknesses in provision: appropriate support for female detainees was not always facilitated and there was only a limited range of adaptations in custody suites for detainees with disabilities.

2.19 Legal rights and entitlements were available in a range of languages but not always in easy read or Braille formats. Staff used professional telephone interpreting services when required but the effectiveness of these services for detainees was hindered by poor equipment.

2.20 We noted that since our last inspection there had been a death in custody which was being investigated by the Independent Police Complaints Commission. Pending this and the result of the inquest it was inappropriate for us to comment further.

2.21 Risk assessments were thorough and appropriately focused on the identification of vulnerability and risk. The management of risk was, however, poor in a number of areas including the removal of clothing with cords, belts and footwear from all detainees and excessive use of anti-rip clothing, often without appropriate justification. Observation levels did not always reflect the risk posed and were not always adhered to.

2.22 Detention was authorised or refused appropriately. Case progression was not always efficient and delays with investigating officers and in accessing appropriate adults, interpreters and legal advisers sometimes resulted in unnecessarily prolonged detention.

---

[4] 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 social worker, and for the making of any necessary arrangements for treatment or care.

2.23 PACE reviews were generally conducted well but many took place significantly early, which was not always in the best interests of the detainee.

2.24 Oversight of bail and 'release under investigation' arrangements were adequate. Most detainees received access to swift justice.

In the custody cell, safeguarding and health care

2.25 Conditions and cleanliness in custody suites varied. There were a number of potential ligature points which posed a risk to detainees and the force. Llanelli was not fit for purpose in its current state.

2.26 Governance of the use of force in custody was not effective. When force was used, it was professional and proportionate but not always as a last resort, particularly when clothes were forcibly removed without good justification. Many detainees were strip-searched, which was not always justified or properly noted in custody records.

2.27 General care for detainees was good. Food and drink were offered readily. Reading materials, outside exercise, visits and showers were not routinely provided.

2.28 Custody sergeants had good awareness of safeguarding children and vulnerable adults. The force kept children out of custody where possible, and detention times, particularly at night, were kept to a minimum. Support for children and vulnerable adults from appropriate adults was timely.

2.29 Despite challenges posed by the vast area of the force, health services provision was generally reasonable.

2.30 There was limited provision in most suites for detainees with substance misuse issues.

2.31 Regular and significant delays in Mental Health Act assessments for those detained in custody were unacceptable. In the previous year, few people had been detained in police custody as a place of safety under Section 136 of the Mental Health Act; this reflected positive action by the force and partners to divert from custody.

Release and transfer from custody

2.32 Sufficient attention was not always given to ensuring that detainees were released safely.

2.33 Most detainees were taken to court in a timely manner, avoiding the necessity for prolonged detention.

Areas of concern and recommendations

2.34 **Area of concern**: The collation and monitoring of data relating to key areas of custody were inadequate.

Recommendation: The force should collate accurate and reliable data across all key areas of custody and use these to robustly assess performance, identify trends and inform organisational learning.

2.35 **Area of concern**: In a number of areas the force was not compliant with Code C of the PACE codes of practice and with authorised professional practice guidance.

Recommendation: The force should take immediate action to ensure that it complies fully with Code C of the PACE Code of Practice and authorised professional practice guidance, in particular with:

- **Section 15.7 Code C: detainees not being informed of a review of their detention taking place while they are asleep;**
- **Section 3.2/3.2A PACE Code C: not providing detainees with a paper copy of their rights and entitlements;**
- **Section 8.5 Code C: the practice of interviewing detainees wearing anti-rip clothing.**

2.36 **Area of concern:** The governance and oversight of the use of force in custody were inadequate, data were unreliable and Dyfed-Powys Police were not recording all instances of the use of force in its custody suites. Force was not always used as a last resort and we were concerned by the number of occasions when force was used to remove detainees' clothing.

Recommendation: The force should strengthen its approach to the use of force by:

- **ensuring that all instances where force is used in custody are properly recorded so that the data are accurate;**
- **monitoring the use of force, with cross referencing to CCTV footage, to provide assurance that its use is fully justified and proportionate to the threat posed;**
- **meeting the requirements to report annually to the Home Office on the use of all force in its custody suites using accurate and robust data.**

2.37 **Area of concern:** There was an over-reliance on the use of anti-rip clothing to manage detainee risk. This was often applied routinely rather than tailored to risk management by setting and adhering to observation levels to meet individual need as set out in authorised professional practice.

Recommendation: The management of risk in custody should be improved. Anti-rip clothing should only be issued in exceptional circumstances and on the basis of an individual risk assessment. Observation levels should be commensurate with risk and should always be conducted at the required frequency.

2.38 **Area of concern:** The length of time that it took for detainees to have mental health assessments was too long, often due to delays in attendance by partner agencies. Delays included three cases where the detainees remained in custody for between 40 and 57 hours.

Recommendation: The force and mental health partners should ensure that mental health assessments are conducted swiftly so that mentally unwell people do not remain in custody.

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 Dyfed-Powys Police had a clear governance structure for custody. Under the direction of the Assistant Chief Constable (ACC), a chief inspector had overall responsibility for the custody function. Four custody managers at inspector level were responsible for the management of the custody suites, dedicated custody sergeants and detention escort officers. This structure provided clear accountability for the safe delivery of custody.

3.2 There were effective internal meeting structures to oversee provision of custody services. A custody performance meeting chaired by a chief inspector fed into a strategic custody meeting chaired by the ACC. Minutes of these meetings showed clear progression of actions relating to custody improvements.

3.3 However, despite this clear strategic framework, we found that the operational delivery of custody services varied among suites. The force was unable to demonstrate that all detainees were dealt with in the same way and there was the potential for inconsistent outcomes.

3.4 Initial training for custody officers and detention escort officers was good. Custody officers undertook a three-week nationally approved training course, completed a professional development portfolio, and shadowed experienced staff before undertaking custody duties. Two days were allocated for refresher training each year. However, not all custody officers received wider operational training which, although not custody based, would have been beneficial to their role.

3.5 There was a reliance on using frontline officers trained in custody to manage busy periods, with little monitoring of the frequency of this or assessment of whether custody services were delivered in the most effective and efficient way. Our observations and case audits indicated that staffing levels were not always adequate to meet demand or to ensure safe detention of all detainees. For example, checks on detainees did not always reflect the observation levels set, as detention escort officers were 'too busy'.

3.6 The force had adopted authorised professional practice (APP) for custody set by the College of Policing. The local custody policy was out of date and was being revised to reflect where additional guidance was needed. We observed some processes and practices which did not comply with APP, in particular the routine removal of belts, clothing with cords and shoes, and the determining and monitoring of observation levels.

3.7 Force leadership in clinical governance and monitoring of health services was generally good, and arrangements for managing the health care contract were satisfactory. Performance was monitored at regular meetings and, while response times remained a challenge, there were consistent efforts to ensure that service requirements were met.

Areas for improvement

3.8 The force should ensure that the strategic approach to custody delivers consistent working practices and good outcomes for detainees across all its suites.

3.9 Staffing levels should be sufficient on all shifts to ensure the safe detention of all detainees and to deliver services in the most effective and efficient way.

Accountability

3.10 The chief inspector chaired monthly performance meetings at which custody inspectors were held to account for the delivery of custody services. Regional reports covered a range of custody activities such as strip-searches, Police and Criminal Evidence Act 1984 (PACE) reviews, Section 136 detainees and children. Performance was discussed and actions identified.

3.11 The collation and monitoring of performance data relating to a number of key areas in custody were inadequate. The force was unable to provide data on the average time in custody following charge, and the average time in custody for immigration detainees. Other data were unreliable and, in some cases, inaccurate, such as the number of strip-searches taking place. This hindered the ability of the force to assess robustly the performance of custody services, identify trends and inform organisational learning.

3.12 A bespoke custody recording system was used and the overall quality of custody records was good, with clear narrative entries. However, detention log entries were not always recorded chronologically. This created a confused picture of the detainee's journey through custody and some key information such as how detainees got home after release was not adequately captured. The custody system could not easily produce key information required for effective performance monitoring.

3.13 There were no adequate mechanisms in place for the force to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. There was some monitoring and oversight of the use of force, but not all incidents were properly recorded and they were not always checked against CCTV footage.

3.14 Data on the use of force in custody suites were collated as recommended by the National Police Chiefs Council, and required by the Home Office annual data return. However, the data were unreliable. Our case audits and CCTV reviews identified cases where restraint and force in custody had not been recorded properly.

3.15 The force did not always comply with Code C of the PACE Codes of Practice for the detention, treatment and questioning of suspects in a number of areas. These particularly related to detainees not being informed of a review of their detention taking place while they were asleep (Section 15.7 Code C), not always providing detainees with a paper copy of their rights and entitlements (Section 3.2/3.2A PACE Code C) and the practice of interviewing detainees while they were wearing anti-rip clothing (Section 8.5 Code C). These were serious concerns and required urgent remedial action.

3.16 Quality assurance included monthly dip sampling of a number of custody records from each suite which were reported at the monthly performance meeting. Trends were identified and lessons learned were shared with custody staff. Despite this, our case audits identified a number of key areas of performance that were not monitored adequately.

3.17 The force demonstrated that it was meeting its obligations under the public sector equality duty. There was an overarching strategic equality plan and some information was published, but there was little specific focus on custody. A review of Equalities Act training for staff had identified a number of gaps and a commitment had been made to provide training and awareness across a range of diversity needs, including transgender detainees, dementia and autism awareness. The Embracing Diversity Board was chaired by the Deputy Chief Constable but this did not have an oversight or monitoring role in relation to custody.

3.18 Some information was collected on the diversity of detainees, but there were some inaccuracies and anomalies, for example the breakdown of detainees by gender and the gender of detainees who were strip-searched. The lack of accurately recorded data prevented the force from identifying areas of potentially disproportionate treatment and the information that was available was not used to determine whether all detainees received fair and equal treatment.

3.19 The force facilitated access to external scrutiny and was open to challenge. Its independent advisory group was represented at strategic meetings and provided effective scrutiny.

3.20 The independent custody visitors (ICVs) provided regular external scrutiny of all custody suites and transparency in the delivery of custody services. Any issues that they identified were reported to the custody inspector. In general, comments from detainees showed that they had received good care while in custody. Most of their concerns related to physical issues in the suites, such as cleanliness. The ICV scheme reported a positive relationship with custody staff and an effective response to issues raised.

Area for improvement

3.21 Diversity data for all detainees should be accurately recorded and monitored to assess whether custody services and processes are delivered fairly and to ensure that any disproportionate treatment is identified and addressed.

Partnerships

3.22 The force had a clear strategic focus on protecting and diverting vulnerable people from custody. It engaged effectively with partners at a strategic level in a number of areas to achieve this. However, statutory partners did not always have sufficient capacity or capability to ensure that this priority led to improved outcomes for detainees.

3.23 A multi-agency mental health protocol was in place, agreed by a wide range of partner agencies. This covered the respective responsibilities of partners when managing individuals detained under Section 136 of the Mental Health Act 1983 and had led to improved management of these individuals. Despite this, in the last year 10 detainees had been taken to police custody as a place of safety. Detainees arrested for an offence who subsequently required a Mental Health Act assessment were often held in custody for long periods waiting for assessments and beds, often due to delays in partner agencies' attendance at suites. In one case a man was held for 57 hours, awaiting appropriate assessment and a suitable bed.

3.24 There was clear engagement and effective joint working for children in custody and there was good support from youth offending teams. The multi-agency Youth Bureau was improving outcomes for children by agreeing appropriate diversions from the criminal justice system and supporting children to prevent re-offending.

3.25 Other diversion services were also available. A women's pathfinder scheme funded by the Office of the Police and Crime Commissioner operated in one area of the force, with a key worker supporting women to prevent re-offending. Of the 90 referrals made to date, 80 women had engaged with the scheme. A veterans' scheme had also been introduced recently and was being promoted to support detainees when leaving 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 staff had a good understanding of vulnerability. The force had provided guidance and training for staff on particular aspects of vulnerability, and it was included as a key theme in other areas of training. Recognising a person's vulnerabilities was regarded as part of every-day policing and it was clear that officers took account of this when deciding whether to arrest an individual or explore other options.

4.2 In general, frontline officers said that they received timely and relevant information from the call centre when responding to incidents, although this was more limited at busy times. Some information on vulnerability was held on the force IT system, including safeguarding referrals, and officers could access some of this directly themselves. In the main, officers had sufficient information on which to base their decisions.

4.3 Frontline officers took individuals detained under Section 136 of the Mental Health Act 1983 to health based places of safety for assessment to avoid taking them to custody wherever possible. However, the availability of mental health services and facilities varied across the force area. This sometimes led to individuals in mental health crisis waiting for long periods in police cars and at the health facilities pending assessment. Alternatively, they were transported to other areas where services were available.

4.4 Support varied for frontline officers dealing with individuals who had committed an offence but were displaying mental ill health. A mental health practitioner based in the call centre provided advice and support to officers and made telephone assessments of individuals, or occasionally attended incidents. Officers regarded this as a valuable resource to help them manage people appropriately. However, this was not available across the whole force area, where local arrangements with mental health providers were relied on to decide whether a person had mental capacity (under the Mental Capacity Act 2005) and to arrange any assessments or support. Officers were clear that they would try to address the person's vulnerability first and the offence second, and gave us a number of examples of this. However, they told us that they sometimes had no choice but to take an individual into custody for a mental health assessment to be arranged.

4.5 There was a very strong focus on preventing children being criminalised and avoiding taking them into custody. During the year to 31 October 2017, 481 children had entered custody, representing 6% of custody throughput. It was evident that officers' primary concern was to determine why a child had offended and identify safeguarding issues. Officers actively sought a range of alternatives such as voluntary interviews, community resolutions and other restorative justice options, and were well supported by youth offending teams to achieve these outcomes.

4.6 The transport of detainees to custody was based on a risk assessment and whether officers were alone with the detainee. Police cars or vans adapted for the safe transportation of detainees were used, although there could be delays in their availability. There was no provision for detainees with mobility issues. Officers told us they had no direct experience of

managing detainees with significant mobility issues but said they would deal with each case on an individual basis. Officers told us that they were unable to get ambulances to attend for detainees with mental ill health, or there were long waits, and police cars were often used. This was inappropriate for people in mental health crisis. Officers sought to mitigate this by using unmarked vehicles when possible.

Area for improvement

4.7 The force should continue to work with health services to ensure that detainees in mental health crisis are transported in ambulances in a timely manner.

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 Engagement with detainees was broadly respectful. Conversations were generally calm, patient and positive, sometimes in challenging circumstances.

5.2 However, we observed a number of working practices which affected the dignity of detainees: some detainees were required to wear anti-rip clothing, sometimes without sufficient justification (see paragraphs 5.18 and 6.15 and area of concern 2.37); detainees walked barefoot despite the availability of alternative footwear; personal clothes were often placed on the floor outside cells instead of in lockers; and detainees had to request toilet paper even though there were adequate supplies (see paragraph 6.22).

5.3 Custody suites were not designed to afford enough privacy for detainees to disclose sensitive and confidential information during booking in or to have private conversations with their legal representatives. Staff tried to mitigate this by booking in one detainee at a time but this was not always practical.

5.4 With the exception of Newtown, cell toilet areas were obscured on all CCTV monitors. However, not enough attention was paid to obscuring CCTV during strip searches which compromised detainees' dignity (see paragraph 6.15). CCTV monitors at Aberystwyth could be seen by detainees in booking-in areas, which was inappropriate.

5.5 There were not always enough female staff to support female detainees in custody. A range of sanitary products was available at all custody suites but they were not routinely offered to female detainees.

5.6 Provision for religious worship was good. A range of books and artefacts to support the main religions were available in all suites and they were stored respectfully.

5.7 There had been some training to help staff recognise and meet the diverse needs of detainees. Training to raise awareness of the individual needs of transgender detainees was being undertaken, which was positive. There was otherwise little focus on protected groups, although staff were confident to identify and address most individual need experienced by detainees in their care.

5.8 There were few adaptations in custody suites for detainees with disabilities. Some suites had adapted showers and exercise yards suitable for detainees with mobility issues. Wheelchairs were available in some suites.

Areas for improvement

5.9 Booking-in areas should afford sufficient privacy. CCTV monitors should only be visible to staff and toilet areas in all cells should be pixelated on CCTV monitors.

5.10 All custody staff should be trained to identify and meet the individual needs of detainees across all protected characteristics.

Communication

5.11 Custody staff could use professional telephone interpreting services to assist detainees who did not speak English. However, not all custody suites had fully functioning dual handsets and staff often relied on speaker phones which lacked privacy and adversely affected the service offered to detainees.

5.12 Legal rights and entitlements were available in a range of languages and staff knew how to access them. Contrary to Police and Criminal Evidence Act 1984 (PACE) Code C, rights and entitlements in other formats such as easy read were not always available and there were no versions in Braille.

5.13 Posters in the most common languages used by communities in the force area advised detainees of their right to free legal advice.

5.14 Hearing loops were available and most staff knew where they were kept and how to use them.

Area for improvement

5.15 All suites should have working double-handset telephones to facilitate telephone interpretation.

Risk assessments

5.16 Standardised risk assessments were carried out promptly and consistently by custody sergeants. The range of questions was comprehensive and appropriately focused on the identification of risk. Risks for detainees in custody for the first time were identified well. Most custody sergeants were skilled at building rapport with detainees and obtaining relevant information to inform their care plan. We saw examples of staff interacting with detainees patiently and compassionately. Arresting officers were asked for their knowledge of detainees to add rigour to the initial risk assessment.

5.17 Risk assessments were routinely cross-referenced against warning markers from the police national computer and historical information on the custody record system. Initial observation levels in detainees' care plans did not always reflect identified risk. They were reviewed regularly, and generally there was sufficient justification for reductions or increases in observation levels. Observations were broadly adhered to, but we found evidence, particularly in detention logs, of observations not being carried out at the required frequency, sometimes recorded as staff being 'too busy', which presented considerable risk to detainees and the force.

5.18 The routine removal of clothing with cords, belts and footwear from all detainees was not in isolation an effective measure for minimising risk. Anti-rip clothing was used to manage risk,

usually with no individual risk assessment (see paragraph 5.2) and justification for its use was inconsistent. In many cases, anti-rip clothing was issued when a detainee refused or was unable to engage with the risk assessment process and sometimes when they had been assessed as low risk or had no history of self-harm. The level of observation was set at too low a level for some detainees who were identified as high risk and had been issued with anti-rip clothing.

5.19 Most staff were well aware of the rousing practice. However, we saw examples of staff shouting at detainees and not entering cells to rouse them in line with force protocol and despite the routine placement of rousing aide memoires on cell doors. Recording of rousing was not always documented in enough detail in detention logs.

5.20 Custody staff were issued with personal anti-ligature knives and most carried them. Despite this, staff in some suites visited cells to unlock detainees but did not carry anti-ligature knives. This was poor practice and posed a potential risk to detainees. An additional concern was the frequency with which anti-ligature knives were used to cut detainees' clothing off. This was inappropriate and risked the tools becoming too blunt for their intended purpose.

5.21 Handovers were generally appropriate and focused on detainee welfare and risk. However, not all were conducted in private or with all custody staff present at the beginning of a shift. Sergeants did not routinely visit detainees in all suites following the handover.

Areas for improvement

5.22 All staff attending detainees' cells should carry anti-ligature knives, which should only be used for their intended purpose.

5.23 All custody staff should be involved collectively in shift handovers.

Individual legal rights

5.24 Custody sergeants booked detainees into custody competently. Arresting officers, in the presence of the detainee, explained fully the circumstances of and reasons for the arrest before detention was authorised. Some custody sergeants told us they rarely refused detention while others said they occasionally refused detention because officers lacked an understanding of PACE Code G[5]. Our case audits and observations indicated that detention was refused appropriately. Some officers consulted custody sergeants about the circumstances of the case before making an arrest to ensure that the necessity test would be met. This was positive.

5.25 Alternatives to custody included adult community resolutions[6], referrals to the youth offending service, fixed penalty notices[7] and voluntary attendance[8]. Voluntary attendance facilities in most custody suites were in full sight of the booking-in areas, which was contrary to the aim of diverting individuals from custody. Records concerning the use of voluntary

5 PACE Code G is the Code of Practice for the Statutory Power of Arrest by Police Officers.

6 Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender, through informal agreement between the parties rather than progression through the criminal justice process.

7 Fixed penalty notices (FPNs) can be issued for a number of road traffic offences and disorder offences like shoplifting, possessing cannabis and being drunk and disorderly in public. If payment is received by the due date, the recipient does not get a criminal conviction.

8 Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

attendance were unreliable but it was reassuring that a task group had been set up to address this (see area of concern 2.34).

5.26 On occasions it took some time to convey detainees to the custody suites because of the large area covered by the force. The journey time was accounted for in most cases and an explanation noted in the custody records.

5.27 Detainees were booked in promptly on arrival at the custody suites. Our analysis of 89 custody records showed that the average waiting time for detention to be authorised was four minutes, much lower than our comparator of 22 minutes for all police forces inspected since March 2016.

5.28 Custody sergeants were aware of the need to keep the time in detention to a minimum and to progress cases quickly. Some custody sergeants liaised with investigating officers to ensure that cases were prioritised, particularly when these involved vulnerable detainees. However, investigations were not always progressed in a timely manner and stays in police custody were prolonged because investigating officers, appropriate adults (AAs) (see paragraph 6.31), legal representatives, interpreters and health care practitioners were not available (see paragraph 6.45). In one case the detainee was transferred from Haverfordwest to Ammanford (90 minutes away) for investigating officers there to deal with him. We were also advised of two recent cases of delay, one at Aberystwyth when a detainee had to be released on bail and one at Newtown where a detainee had to be held overnight to facilitate the attendance of interpreters from outside the force area. Our custody record analysis showed an average length of detention before charge of 10 hours 23 minutes, which was slightly higher than the comparator for all police forces inspected since March 2016.

5.29 Custody staff reported a good relationship with Home Office immigration enforcement officers and told us that most immigration detainees were moved on within 24 hours, although longer delays were experienced on occasions. The force was unable to provide reliable data on the number of immigration detainees held or the average time that they spent in police custody following service of an IS91[9] warrant of detention (see paragraph 3.11 and area of concern 2.34).

5.30 Custody sergeants advised detainees of their three main rights[10] during booking-in. A written notice was available setting out a detainee's rights and entitlements, but not all custody sergeants routinely offered this to detainees (see area of concern 2.35), and we found out-of-date versions in one suite.

5.31 Most custody sergeants were not aware of translated documents – such as authorisation of detention and charge details – in 51 languages on the force intranet site[11].

5.32 Detainees were advised that they could inform someone of their arrest, which staff facilitated. Detainees were often allowed to speak to their nominated representative while still at the booking-in desk, which was positive.

5.33 All detainees were offered free legal representation. If a detainee declined, custody sergeants did not always ask them, or record, why they did not wish to use this service (see area of concern 2.35). There were enough interview/consultation rooms in all custody suites for

---

9 An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative action – for example, if there is a likelihood that they may abscond or that their removal from the UK is imminent.

10 The right to have someone informed of their arrest, the right to consult a solicitor and access free independent legal advice, and the right to consult the PACE codes of practice.

11 PACE Code C Annex M details the documents considered essential for the creation and provision of written translations.

detainees to consult their legal representatives in private. Detainees wishing to speak to legal representatives on the telephone could not do so in private. All telephone calls were taken at the booking-in desks or, at Brecon, in a small wall mounted booth near the booking-in desk, none of which afforded sufficient privacy (see area of concern 2.35). Legal representatives were given a printout of the front sheet of their client's custody record on arrival at the suites.

5.34 Detainees were told that they could read the PACE codes of practice[12] during booking in, but these were not routinely explained. Formal copies of PACE Code C were not available and we were not confident that detainees would have ready access to up-to-date versions if requested (see area of concern 2.35).

5.35 It was positive that detainees were not interviewed if they were under the influence of alcohol or drugs. We observed detainees regularly being interviewed wearing anti-rip clothing and with no footwear. This was contrary to the PACE codes of practice (see paragraphs 5.2 and 5.18 and area of concern 2.35).

5.36 The management of refrigerators and freezers was inadequate in some custody suites. We found some old elimination DNA samples and exhibits in a number of suites, including the contingency suites, which required attention. In Aberystwyth a number of fridges and freezers were filled almost to capacity, which was inappropriate as these should not have been located in the custody environment.

PACE reviews

5.37 PACE reviews were undertaken by dedicated custody and operational duty inspectors across the force area. Some timely and appropriate face-to-face and skype reviews took place at the time of the inspection, which was good. Our case audits revealed several examples of reviews conducted early, often with no record of why this was in the best interests of the detainee. In our custody record analysis, 54 detainees had required initial reviews, 25 of which had been conducted early, some significantly so. For example, in one case the review was conducted only 48 minutes after the detainee arrived in custody and with no record to justify this. Custody sergeants confirmed that reviews were regularly conducted early, particularly at night when only one inspector was on duty after 2am to cover the whole force area. Our analysis indicated that late reviews were rare but one took place 9 hours 27 minutes after the detainee's detention was authorised, again with no justification recorded (see area of concern 2.35).

5.38 Twenty-three of the 54 detainees who required an initial review had a face-to-face review and only four were conducted over the telephone, which was positive in the context of the size of the force area. Twenty-two of the initial reviews were carried out while the detainee was asleep. Our case audits also disclosed a number of cases where detainees had been asleep during their case review with no evidence in logs that the detainee had been informed of this on waking or reminded of their rights and entitlements (see area of concern 2.35).

5.39 In our audit of children's cases, we found two instances where reviews had been conducted remotely over the telephone and in one case the child was not spoken to by the inspector when it would have been reasonable to do so. Although PACE allows for this, such practices fail to take into account the specific needs of children in custody (see area of concern 2.35).

[12] PACE Code C is the revised Code of Practice for the detention, treatment and questioning of persons by Police Officers.

Access to swift justice

5.40 Dyfed-Powys Police had prepared well for the changes to pre-charge bail and the introduction of 'released under investigation' brought about by the Police and Crime Act 2017 introduced in April 2017. Clear procedures had been established with accountability for decision making and robust daily and weekly monitoring which ensured that crime suspects were dealt with swiftly. We found good use of rationale by investigating officers to justify 'necessity and proportionality' when supporting bail applications to custody officers.

5.41 Most applications for bail with conditions that restricted suspects' movements were proportionate and reflected the adverse impact on freedom of movement. However, some cases lacked information to justify the use of conditional bail and custody officers passed these applications to inspectors who incorrectly authorised the use of bail.

5.42 The crime investigation logs that we audited demonstrated strong evidence of regular reviews of the continuing necessity for bail and performance management information which ensured that suspects received swift access to justice.

5.43 The requirements of the changes to pre-charge bail had been grasped and the force was establishing consistency in recording rationale to decide when the use of conditional bail was appropriate.

Complaints

5.44 Complaints procedures in English and Welsh were publicised in custody suites. Complaints leaflets were only available in some custody suites. Custody staff told us that if a detainee wished to make a complaint while in custody, this was noted on the custody record and the custody inspector or operational duty inspector was notified. Inspectors confirmed that they decided whether to take the complaint from the detainee while still in custody or arrange for it to be taken later. We saw an inspector dealing with a complaint from a detainee at Ammanford, but the custody record and complaints database did not indicate if this was resolved locally or forwarded to the professional standards department.

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

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

Physical environment is safe

6.1 The custody estate in Dyfed-Powys comprised five full-time designated suites and two contingency suites. Only one of the two contingency suites was fit for purpose and Llanelli did not meet the rigorous standards required of detention.

6.2 Conditions and cleanliness in the suites varied. Some suites were very clean while others were dirty, with ingrained dirt on the benches and staining on walls and floors. Most exercise yards were covered with moss and detritus. There was very little graffiti.

6.3 The limited cleaning contract delivered an inconsistent service which often relied on custody staff, especially at weekends. The specialist cleaning service was prompt when required.

6.4 Daily cell checks were not always completed. When defects were reported, basic repairs were carried out very quickly. More complicated work, such as the flooring at Brecon or flaky paint at Haverfordwest, took longer and some cells had been out of action for long periods. We identified several potential ligature points in communal areas and/or cells in most custody suites, many of which custody staff were not aware of. This posed a risk to detainees and the force. We provided the force with a detailed, illustrative report at the end of the inspection.

6.5 Staff knowledge of fire evacuation procedures was good but only one suite had enough handcuffs to evacuate detainees safely in an emergency if the suite was at full capacity. There had been an emergency evacuation exercise in most suites in the previous six months. Fire drills took place and were recorded centrally, although record-keeping in the suites was poor.

6.6 Cell call bells were usually explained to detainees and most were answered promptly.

6.7 Health care practitioners carried out regular checks on standardised red emergency equipment rucksacks in medical rooms and wall mounted automated external defibrillators located by custody desks. Despite this, some monitoring equipment was not maintained appropriately. A protocol with the force for oxygen had been agreed and stocks were due to be delivered to suites. The two contingency suites did not have all the required medical equipment and some medical supplies were out of date.

Areas for improvement

6.8 Llanelli should only be used as a custody suite to hold detainees if significant attention is given to making it safer and fit for purpose.

6.9 Cleaning arrangements should ensure that cells and communal areas are thoroughly cleaned each day.

6.10 The force should address the safety issues arising from potential ligature points in cells and communal areas by eliminating them or mitigating the risks posed.

Safety: use of force

6.11 Oversight of the use of force in custody was ineffective. Data on the use of force were inaccurate and we found incidents that were not properly recorded (see paragraph 3.14 and area of concern 2.34). Most custody staff were up to date with safety training but many did not submit individual forms to justify use of force. Entries in detention logs often lacked detail or rationale for the use of force.

6.12 There was no up-to-date local policy or guidance on the equipment that custody sergeants were expected to carry. We found inconsistencies across suites: some carried irritant/incapacitant spray (PAVA) and batons, while others did not. We were advised that in the previous 12 months taser and batons had not been used in custody and that PAVA had been used on five occasions.

6.13 We reviewed in depth 21 recent incidents of use of force, including cross-referencing against CCTV footage. There was no systematic approach to retaining or downloading footage. In some suites footage of all incidents was downloaded and retained, which was positive. However, in the five cases where PAVA had been used in the previous year, no CCTV footage had been retained. Our review of associated custody and use of force records did not indicate that the use of PAVA was always proportionate to the threat posed in the controlled custody environment.

6.14 Detainees' clothes were forcibly removed in 16 of the 21 incidents that we cross referenced against CCTV. We did not consider that force was used as a last resort in most of these cases. There was often limited or no negotiation with detainees. The removal of clothes with no good reason sometimes led to the escalation of adverse reactions from detainees and the requirement for the use of force.

6.15 Despite our concerns over the initial use of force, we found that once staff had committed to using force it was handled professionally and incidents were managed well and lasted for the minimum time necessary. We found only a few learning points in three cases including: an officer putting pressure on the back of a detainee in the prone position; poor technique used to carry a detainee; and the head of a detainee being covered with anti-rip clothing for a short period. Good attention was paid in most instances to maintaining the dignity of detainees whose clothes had been removed. In a few cases involving male detainees, this was not the case and they were left naked when staff exited the cell, which was undignified.

6.16 Detainees did not always arrive in custody in handcuffs, which was positive. However, some compliant detainees remained in handcuffs for far too long after arrival.

6.17 Data showed that 1,685 detainees had been strip-searched in the last 12 months.[13] This represented 21% of the throughput, which was very high. We discovered that this figure was not accurate and included the removal of clothing for reasons of safety consistent with a section 54 search[14] but inconsistent with annex A of Police and Criminal Evidence Act 1984 (PACE) Code C. Strip-searching and removal of clothing for other reasons were not always justified or recorded well enough. In a few cases, strip-searches and removal of clothes were conducted when CCTV was visible to other staff in the custody suite, which was unacceptable.

Areas for improvement

6.18 All staff who are involved in the use of force against a detainee should submit an individual use of force form.

6.19 Handcuffs should be removed from compliant detainees at the earliest opportunity.

6.20 Recording and justification for strip-searching should be improved. Detainees should only be strip-searched when there is appropriate justification. Strip-searches should be conducted in a manner which maintains the dignity of the detainee.

Detainee care

6.21 The provision of food and drinks was good. During the booking-in process, detainees were asked if they had any dietary requirements. If stocks of food were not suitable, alternative arrangements were made, including staff buying appropriate replacements or arranging with detainees' friends or family to supply them. The wide range of microwave meals available included vegan, vegetarian and halal options. Adequate portions of food were served at designated meal times and on request by detainees. Kitchens were clean and adequately equipped. Hot drinks, fruit squash and drinking water were offered to detainees regularly.

6.22 Sufficient replacement clothing was available in all suites, including jogging bottoms, sweatshirts, T-shirts and underwear, for detainees whose clothes had been seized for evidence or were soiled. Replacement clothes were also issued to detainees who had cords in their own clothes which were routinely removed to mitigate self-harm risks (see paragraph 5.18). Shoes were removed from all detainees and, although good stocks of plimsolls were available in all suites, they were not always offered and we saw some detainees walking around the suite without any shoes (see paragraph 5.2). Toiletries and sanitary items were available to detainees in all suites. Toilet paper was not routinely provided, contrary to authorised professional practice, and some detainees had to ask for it. Not all cells had hand-washing facilities.

6.23 All suites had showers, but most were not sufficiently private and many posed concerns about ligatures. Showers were not offered routinely. Custody records indicated that only 9%

[13] Annex A PACE Code C 10. A strip-search may take place only if it is considered necessary to remove an article which a detainee would not be allowed to keep and the officer reasonably considers the detainee might have concealed such an article. Strip-searches shall not be routinely carried out if there is no reason to consider that articles are concealed.

[14] Section 54 of PACE 1984 (4) Clothes and personal effects may only be seized if the custody officer—
(a)believes that the person from whom they are seized may use them (i)to cause physical injury to himself or any other person.

of detainees, and less than a third who had been in custody overnight, were offered a shower.

6.24 Facilities for time in the open air varied. External areas were covered by CCTV and detainees assessed as low risk were sometimes allowed to use them without staff supervision, but this approach was inconsistent. Our custody record analysis showed that only 6% of detainees had been offered and/or accepted a period of exercise outside.

6.25 A reasonable range of reading materials was available for detainees in most suites including magazines and books suitable for children and a limited range in languages other than English. Records showed that nine detainees (10%) had been offered access to reading materials, and only three of the ten detainees held for longer than 24 hours had been offered this. Most detainees were only given reading materials on request.

6.26 Most suites had designated visits facilities or allowed a visit to take place in an interview room inside the suite when necessary. The facilities were clean and easily accessed. Staff said they were used regularly and entries in custody records reflected this.

Areas for improvement

6.27 Detainees should be provided with replacement footwear routinely when theirs has been removed.

6.28 Detainees should automatically receive toilet paper in their cells barring risk assessment indicators, to reflect authorised professional practice guidance.

6.29 Detainees, particularly those held for longer periods, should be routinely offered exercise, showers and reading materials to improve their care and welfare while in custody.

Safeguarding

6.30 Custody staff whom we spoke to had a good understanding of how to safeguard vulnerable adults and children. Some safeguarding training had been arranged but not all custody officers had benefited from this, and there was no policy framework or guidance for safeguarding in custody. The involvement of custody officers in safeguarding varied and custody officers were unclear about their responsibility to make referrals. They told us that they would ensure that arresting or investigating officers made referrals, but there were no records or monitoring to ensure that referrals had been made appropriately.

6.31 Most detainees received timely support from appropriate adults (AAs). Custody sergeants made early requests, and arresting officers tried to arrange AAs while children were on their way to custody which resulted in few delays. In the cases that we examined, AAs arrived quickly and no child waited longer than three hours. Waits for AAs for vulnerable adults were more variable, and slightly longer on average than for children. Some delays were caused by travel time but the reasons for delays were not always recorded.

6.32 Appropriate adults were required to attend for the rights and entitlements to be explained and either remained or returned for other components of custody processing. However, we were told that fingerprinting and photographing of vulnerable adults were sometimes carried out with no AA present, which was concerning. Parents or other family members or friends were used in the first instance but otherwise AAs were provided through the youth offending teams for children and an independent contractor for vulnerable adults. These

services were available 24 hours a day, although it was sometimes difficult to secure a social worker for children at night. There was a guidance leaflet for AAs new to the role and custody officers told us they also explained the process.

6.33 There was no guidance on determining if a person was vulnerable and required an AA, but officers told us they were confident to use their professional judgement, often in discussion with a health care practitioner. Some cases that we examined suggested that an AA should have been considered but it was not clear if this had happened. This approach did not ensure that decisions on whether to call an AA for a vulnerable adult were made consistently.

6.34 Monitoring of the independent contracted AA service had started recently to assess the use of the service and performance against the target times for AAs' arrival. This showed that they arrived on time in most cases. Custody records did not always indicate when other AAs were called, their arrival time or their relationship to the detainee.

6.35 Children brought into custody were well cared for. Where possible, custody officers placed children in interview rooms rather than a cell. Family members or an AA were encouraged to remain with the child throughout their detention to ensure their welfare. This happened in many of the cases that we looked at, which was positive. Food and drink were regularly offered and arrangements were made for food to be brought in if the child did not eat the meals provided.

6.36 Risk assessments were thorough and supplemented by a 'children in custody' checklist which helped to identify children's needs and prompted the custody officer to consider child sexual exploitation, for example, or other safeguarding issues. In the cases that we looked at, all girls had been allocated a female officer in line with legislative requirements. All children were released to the care of a family member or AA to return home, although this was not always clearly recorded.

6.37 There was a strong focus on avoiding bringing children into custody or, if this was not possible, keeping detention time to a minimum. Custody officers considered refusing detention or releasing children under investigation to be dealt with through alternative means, especially if this avoided overnight detention. In most cases children spent less than six hours in custody.

6.38 During the year to 31 October 2017, eight children had been charged and refused bail. In these circumstances children's social services had a statutory duty to transfer the child from custody to other suitable accommodation. However, despite thorough discussion with social services and escalation procedures, only one child had been moved to alternative accommodation. The other seven children had remained in police custody until their court appearance because of a lack of suitable accommodation. There was no monitoring of this with partners at a strategic level, and, although the numbers were low, it was a poor outcome for the children involved.

6.39 All children entering custody were reviewed by inspectors and reported to the monthly performance meetings. Any child held overnight was discussed at the local police daily management meetings. This provided a good level of scrutiny of the necessity for arrest, the risk assessment and the length of detention. However, there was no overarching information on the number of children detained overnight, to identify trends or form the basis of discussions with partners.

Areas for improvement

6.40 Vulnerable adults should only have their fingerprints, photograph and DNA taken in the presence of an appropriate adult.

6.41 Record keeping in relation to appropriate adults should be improved so that the force can determine the consistency of early support and the effectiveness of decisions on whether a detainee requires an AA because of their vulnerability.

6.42 The force should continue to work with local authority partners to avoid the overnight detention of children in custody by transferring them to suitable alternative accommodation.

Governance of health care

6.43 Castle Rock Group (CRG) was contracted to deliver a primary health care service. Clinical governance structures were sound with agreed key performance indicators and regular clinical audits to ensure the safe and timely care of detainees.

6.44 The force relied on CRG performance data. The overall performance against the target response time of 85% in 60 minutes was 73% at September 2017. There was reasonable escalation of delays and bimonthly contract meetings contributed to monitoring and learning.

6.45 A contract manager/clinical lead (a health care practitioner) and a lead forensic medical examiner (FME) were supported by a national senior management structure. Planned staffing comprised two HCPs and one FME for each shift. Some detainees waited for too long to see a health practitioner which extended their time in custody. Recent rotas displayed some gaps which were largely mitigated by contingency planning and clinical prioritisation.

6.46 The FME rota also covered the three sexual assault referral centres, which compounded delays in response times. Custody staff said that some FMEs were reluctant to travel to suites towards the end of their shift and they often had to call the FME/HCP on the next shift because of travel times. Custody staff also spoke of instances of FMEs appearing reluctant to attend and dealing with issues by telephone, which they felt was not always appropriate.

6.47 Some HCPs/FMEs were directly employed by CRG supplemented by regular bank HCPs, self-employed FMEs and FMEs contracted by MedTeam (a CRG partner agency). There was a system for ensuring compliance with professional registration and mandatory training.

6.48 Access to management supervision for employed staff was good. Clinical supervision was underdeveloped. New HCPs and FMEs were provided with an induction programme. A few HCPs were not authorised to take venous bloods and/or forensic samples and this was being addressed.

6.49 A suitable range of up-to-date health policies was held in folders in the suites and accessible online. The communicable diseases policy lacked a local contacts list. A range of scheduled and suitable audits was carried out.

6.50 The confidential complaints process had not been used in the previous year. The patient feedback scratch cards were not routinely offered to detainees. There was a system for reporting and learning from incidents, 43 of which had been reported in the previous six months. There was evidence that trends had been analysed and lessons learned and shared.

6.51 All suites had adequate clinical facilities which were clean, but contained some fixtures and fittings that did not comply with infection prevention and control standards, including fabric covered seats in all medical rooms and non-compliant sink taps (Aberystwyth, Brecon and Haverfordwest). Clinical rooms lacked essential equipment, including examination lamps and privacy screens in all suites, and telephones or functioning internet in some suites. In two suites the keys to the equipment cupboard were on the police bunch of keys. This was rectified during the inspection.

6.52 Cleaning schedules demonstrated daily cleaning by contract cleaners but not to NHS equivalent standards. In some suites, detention escort officers told us they were expected to carry out regular deep cleaning but there was no checklist to support this. HCPs were expected to carry out regular cleaning of clinical surfaces but checklists were not always completed.

Areas for improvement

6.53 Detainees should be seen within agreed response times and should not be compromised by FME attendance at sexual assault referral centres.

6.54 Essential equipment in medical rooms, including telephones, internet access, adjustable and intact examination couches, examination lights and privacy screens, should be provided to ensure safe and appropriate assessment of detainees.

Patient care

6.55 Custody staff referred detainees according to need or the detainee's request. There was good collaborative working between health and custody staff and custody staff were positive about the care provided for detainees. Health and custody staff confirmed that most consultations were conducted in the medical room except when there was a risk or the detainee's condition prevented it. Custody staff could act as chaperone if required.

6.56 Health professionals did not have access to custody records. HCPs and some FMEs completed an electronic clinical record (FME system), but other FMEs either did not have access or elected to use a paper form (DP police form 450) which did not include consent to share information. Care plans from the FME system or the paper form were printed, copied and shared with custody staff. Records that we reviewed were reasonable, but some HCP care plans and most FME records simply repeated the assessment or past medical history using medical terminology rather than clear information to help identify deterioration. Some records contained a level of detail that risked compromising confidentiality. Records were secure and Caldicott compliant[15].

6.57 Police regularly obtained patients' own prescribed medicines from their homes. Custody staff could give detainees simple 'over the counter' remedies, including pain relief and Salbutamol inhalers (for asthma) and Glyceryl Trinitrate spray (for angina) in emergency situations, subject to telephone authorisation by an FME. There was no procedure for confirming this in writing. Police took detainees on prescribed opiate substitution to collect it from the chemist. Nicotine replacement therapy was available and offered by custody staff, but dosages were inconsistent and there was no force protocol.

[15] Overseeing use and confidentiality of personal health information.

6.58 Medicine administration by HCPs was safe and they were able to use a reasonable range of patient group directives[16]; individual directives were not signed by HCPs.

6.59 Detainees' medicines were stored in property lockers but we were told that some individual dose envelopes were put on the clipboard near the custody desk, which could pose a risk with scheduled controlled drugs. Symptomatic relief for drug and alcohol withdrawal was easily available, although this was not sent with the detainee to court which could cause serious health consequences for those withdrawing from alcohol.

6.60 Stock management and storage of medicines were generally good with separate cabinets for custody staff medicines. HCPs carried out daily checks of scheduled controlled drugs and Paracetamol and recorded checks of all medicines each week. Variations were identified and addressed promptly. Glucagon (glucose injection) and Lactulose (for constipation) were not always marked with an opening/expiry date. Much of patients' own and expired medicines were awaiting safe disposal (Haverfordwest, Ammanford). There was effective security of medicine keys with digital wall safes accessible only by health professionals. The medicine cabinet at Llanelli was wooden and not compliant with national regulations.

Area for improvement

6.61 A single shared electronic clinical record should be completed by all health professionals, including consent to examination, treatment and information sharing. Care plans should be formulated to support custody staff in identifying and monitoring deterioration. Medical details on shared care plans should include only sufficient information to keep the detainee safe.

Substance misuse

6.62 Workers from local drug services maintained regular contact with custody staff by telephone or weekly visits to collect referrals. They did not visit each day, losing the opportunity to engage with detainees with alcohol and/or drug problems. The exception was at Brecon where daily visits from Monday to Thursday increased the take-up of services. Since April 2017, each suite had provided target drug testing for heroin, cocaine and crack cocaine linked to trigger offences with the authorisation of inspectors. Detainees testing positive were required to meet two substance misuse appointments. Tests were not consistent at Brecon because not all custody staff were trained, but conditional cautions were used for minor drug offences which required the detainee to attend three substance misuse appointments.

6.63 Dyfed Drug and Alcohol Service (DDAS) and Kaleidoscope services both operated from Monday to Friday and had positive links with the police. At Aberystwyth, there was no regular contact with custody staff but telephone referrals could be made. At Ammanford, a worker attended the suite if an urgent request was made by custody staff. At Haverfordwest, a worker telephoned or visited the suite daily and responded to custody staff calls. At Brecon, a Kaleidoscope criminal justice worker visited each morning from Monday to Thursday. At Newtown a criminal justice worker telephoned each morning and visited once a week to collect referrals, with plans to restore visits when full staffing was in place. A pilot scheme had started in some of the force areas on 9 November 2017 whereby the first appointment following a positive drug test for a trigger offence took place before the person left the custody suite. This was a positive initiative. Workers made contact with local

[16] Authorise appropriate health care professionals to supply and administer prescription-only medicine.

community substance misuse services through the single point of contact directory for detainees who lived out of the area.

6.64 At weekends and out of hours DDAS had a central mailbox and email alerts were generated by police electronic referral and diverted to the area worker.

6.65 Workers had limited contact with health care or mental health practitioners but spoke of constructive working relationships. Kaleidoscope had a protocol for direct referral to mental health services for clients with dual diagnosis needs.

6.66 Substance misuse workers could not make entries on the custody record to ensure continuity of care. There was no access to clean injecting equipment but substance misuse services could signpost to local community facilities.

6.67 Children were referred to the CAIS (provider of personal support services in Wales) which operated in conjunction with local youth offending services.

Area for improvement

6.68 All detainees identified as at risk of drug or alcohol problems should be offered services in custody or after release irrespective of their offence history.

Mental health

6.69 Hywel Dda University Health Board delivered services to Dyfed, and Powys Teaching Health Board to the Powys area. The force co-chaired the two multi-agency Section 136 meetings and was a key partner to the respective protocols. Minutes demonstrated a dialogue between partners with good scrutiny and learning from individual case reviews.

6.70 An excellent street triage system had operated in Dyfed since 2015. On Thursday to Sunday evenings between 4pm and midnight, a mental health practitioner and police officer were based in the force communication and control room. Incoming calls were screened and referred to the team. Telephone/radio advice was given to frontline officers and people they were attending. The team could attend the incident using an unmarked vehicle equipped as a consultation/assessment room. Future funding for the scheme had been agreed, including an extension of the hours offered.

6.71 There were three Dyfed health based places of safety, with one space reserved for children and an additional contingency space, and three spaces serving Powys. There was a real drive to divert people from custody, although there had been 10 detentions under Section 136 in the previous 12 months. There was no similar service in Powys.

6.72 There was no liaison and diversion service in the force area. There was good and early identification of mental health needs by custody staff and HCPs, and care of vulnerable, mentally unwell people was sensitive and focused on individual need. On a few occasions police officers had brought detainees to custody if they believed they would be dealt with more quickly. We observed this in Aberystwyth with excellent joint working between frontline and custody officers to secure appropriate and timely assessment of a distressed and vulnerable young man.

6.73 Mental health trained HCPs could refer directly to mental health services and others were expected to discuss the referral initially with an FME. In all suites there was telephone access to the local CRISIS (emergency mental health) teams, community mental health team and,

out of hours, an on-call psychiatrist. At Haverfordwest, a mental health practitioner visited or telephoned the suite four days a week.

6.74 Detainees regularly waited too long for a Mental Health Act assessment (see area of concern 2.38). Attendance of approved mental health workers was often delayed, but the real challenge was securing a Section 12 (MHA) approved doctor. There was a lack of approved doctors, who were often committed elsewhere. There was no rota system and we were told that health boards were discussing this. The geographical distances meant that health professionals spent a long time travelling to suites. This was compounded by delays in securing appropriate ambulance transport.

6.75 We found three cases where detainees had waited 40 hours, 44 hours and 57 hours for assessment and transfer to hospital.[17]

Good practice

6.76 *Excellent joint working between frontline police and mental health services and the provision of a mobile consultation/assessment facility enabled vulnerable and distressed people in the Dyfed area to have early intervention which was not stigmatising and potential diversion from custody and formal mental health services. Formal evaluation of the service was being completed.*

[17] 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.

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 Pre-release risk assessments were not completed consistently by custody sergeants. Some sergeants completed the template in the detainee's presence while others did so after they had left, which was poor practice. The standardised template did not include enough questions to ensure the safe release of detainees, for example custody staff were not prompted to ask or record routinely how a detainee planned to travel home after release. Records of pre-release risk assessments in many detention logs were cursory and lacked detail on how a detainee's risk was assessed before their release. Despite this, most assessments that we observed demonstrated that custody sergeants were focused on securing a safe release for detainees and many sergeants showed a genuine concern for the people in their care.

7.2 Custody sergeants spoke to detainees before release about community support agencies. Staff recorded in detention logs when they had referred or signposted detainees to agencies. We observed one detainee who had been charged with a drink driving offence being referred to an alcohol education course and a number of others to a range of substance misuse services in the community.

7.3 A generic support leaflet in a range of languages was issued routinely to detainees on release. However, this leaflet was out of date. An alternative up-to-date leaflet was used in two suites.

7.4 No travel warrants were available to provide financial support to detainees who did not have the means to travel home on release. A limited amount of petty cash could be used for detainee travel, but not all staff were aware of this. Custody staff regularly facilitated telephone calls to family and friends or arranged transport home with patrol officers. Transport for children and vulnerable detainees was routinely organised by custody staff.

7.5 Most person escort records that we checked were completed well. However, while most included specific risk information, which was good, some warning markers were identified without the dates of the incidents. Confidential medical records were not always sealed in envelopes, which was inappropriate.

Areas for improvement

7.6 Custody sergeants should routinely complete the pre-release risk assessment with detainees present to secure their safe release from custody.

7.7 The pre-release support leaflet should contain up-to-date information.

7.8 Confidential medical records should be placed in a sealed envelope when attached to a person escort record.

Courts

7.9 The throughput of detainees to court was low from most of the suites. Flexible arrangements with the local courts prevented detainees from being held in police custody for longer than necessary. Since the last inspection, all the suites now communicated directly with the listings team in their local courts to arrange the transfer of detainees required to attend a hearing without delay. In some cases, custody staff escorted detainees to the local court to reduce delays.

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

Areas of concern and recommendations

8.1 **Area of concern:** The collation and monitoring of data relating to key areas of custody were inadequate.

Recommendation: The force should collate accurate and reliable data across all key areas of custody and use these to robustly assess performance, identify trends and inform organisational learning. (2.34)

8.2 **Area of concern**: In a number of areas the force was not compliant with Code C of the PACE codes of practice and with authorised professional practice guidance.

Recommendation: The force should take immediate action to ensure that it complies fully with Code C of the PACE Code of Practice and authorised professional practice guidance, in particular with:

- Section 15.7 Code C: detainees not being informed of a review of their detention taking place while they are asleep;
- Section 3.2/3.2A PACE Code C: not providing detainees with a paper copy of their rights and entitlements;
- Section 8.5 Code C: the practice of interviewing detainees wearing anti-rip clothing. (2.35)

8.3 **Area of concern:** The governance and oversight of the use of force in custody were inadequate, data were unreliable and Dyfed-Powys Police were not recording all instances of the use of force in its custody suites. Force was not always used as a last resort and we were concerned by the number of occasions when force was used to remove detainees' clothing.

Recommendation: The force should strengthen its approach to the use of force by:

- ensuring that all instances where force is used in custody are properly recorded so that the data are accurate;
- monitoring the use of force, with cross referencing to CCTV footage, to provide assurance that its use is fully justified and proportionate to the threat posed;
- meeting the requirements to report annually to the Home Office on the use of all force in its custody suites using accurate and robust data. (2.36)

8.4 **Area of concern:** There was an over-reliance on the use of anti-rip clothing to manage detainee risk. This was often applied routinely rather than tailored to risk management by setting and adhering to observation levels to meet individual need as set out in authorised professional practice.

Recommendation: The management of risk in custody should be improved. Anti-rip clothing should only be issued in exceptional circumstances and on the basis of an individual risk assessment. Observation levels should be commensurate with risk and should always be conducted at the required frequency. (2.37)

8.5 **Area of concern:** The length of time that it took for detainees to have mental health assessments was too long, including three cases where the detainees remained in custody for between 40 and 57 hours.

Recommendation: The force and mental health partners should ensure that mental health assessments are conducted swiftly so that mentally unwell people do not remain in custody. (2.38)

Areas for improvement

Leadership, accountability and partnerships

8.6 The force should ensure that the strategic approach to custody delivers consistent working practices and good outcomes for detainees across all its suites. (3.8)

8.7 Staffing levels should be sufficient on all shifts to ensure the safe detention of all detainees and to deliver services in the most effective and efficient way. (3.9)

8.8 Diversity data for all detainees should be accurately recorded and monitored to assess whether custody services and processes are delivered fairly and to ensure that any disproportionate treatment is identified and addressed. (3.21)

Pre-custody: first point of contact

8.9 The force should continue to work with health services to ensure that detainees in mental health crisis are transported in ambulances in a timely manner. (4.7)

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

8.10 Booking-in areas should afford sufficient privacy. CCTV monitors should only be visible to staff and toilet areas in all cells should be pixelated on CCTV monitors. (5.9)

8.11 All custody staff should be trained to identify and meet the individual needs of detainees across all protected characteristics. (5.10)

8.12 All suites should have working double-handset telephones to facilitate telephone interpretation. (5.15)

8.13 All staff attending detainees' cells should carry anti-ligature knives, which should only be used for their intended purpose. (5.22)

8.14 All custody staff should be involved collectively in shift handovers. (5.23)

In the custody cell, safeguarding and health care

8.15 Llanelli should only be used as a custody suite to hold detainees if significant attention is given to making it safer and fit for purpose. (6.8)

8.16 Cleaning arrangements should ensure that cells and communal areas are thoroughly cleaned each day. (6.9)

8.17 The force should address the safety issues arising from potential ligature points in cells and communal areas by eliminating them or mitigating the risks posed. (6.10)

8.18 All staff who are involved in the use of force against a detainee should submit an individual use of force form. (6.18)

8.19 Handcuffs should be removed from compliant detainees at the earliest opportunity. (6.19)

8.20 Recording and justification for strip-searching should be improved. Detainees should only be strip-searched when there is appropriate justification. Strip-searches should be conducted in a manner which maintains the dignity of the detainee. (6.20)

8.21 Detainees should be provided with replacement footwear routinely when theirs has been removed. (6.27)

8.22 Detainees should automatically receive toilet paper in their cells barring risk assessment indicators, to reflect authorised professional practice guidance. (6.28)

8.23 Detainees, particularly those held for longer periods, should be routinely offered exercise, showers and reading materials to improve their care and welfare while in custody. (6.29)

8.24 Vulnerable adults should only have their fingerprints, photograph and DNA taken in the presence of an appropriate adult. (6.40)

8.25 Record keeping in relation to appropriate adults should be improved so that the force can determine the consistency of early support and the effectiveness of decisions on whether a detainee requires an AA because of their vulnerability. (6.41)

8.26 The force should continue to work with local authority partners to avoid the overnight detention of children in custody by transferring them to suitable alternative accommodation. (6.42)

8.27 Detainees should be seen within agreed response times and should not be compromised by FME attendance at sexual assault referral centres. (6.53)

8.28 Essential equipment in medical rooms, including telephones, internet access, adjustable and intact examination couches, examination lights and privacy screens, should be provided to ensure safe and appropriate assessment of detainees. (6.54)

8.29 A single shared electronic clinical record should be completed by all health professionals, including consent to examination, treatment and information sharing. Care plans should be formulated to support custody staff in identifying and monitoring deterioration. Medical details on shared care plans should include only sufficient information to keep the detainee safe. (6.61)

8.30 All detainees identified as at risk of drug or alcohol problems should be offered services in custody or after release irrespective of their offence history. (6.68)

Release and transfer from custody

8.31 Custody sergeants should routinely complete the pre-release risk assessment with detainees present to secure their safe release from custody. (7.6)

8.32 The pre-release support leaflet should contain up-to-date information. (7.7)

8.33 Confidential medical records should be placed in a sealed envelope when attached to a person escort record. (7.8)

Good practice

8.34 Excellent joint working between frontline police and mental health services and the provision of a mobile consultation/assessment facility enabled vulnerable and distressed people in the Dyfed area to have early intervention which was not stigmatising and potential diversion from custody and formal mental health services. Formal evaluation of the service was being completed. (6.76)

Section 9. Appendices

Appendix I: Inspection team

Norma Collicott	HMICFRS inspection lead
Fionnuala Gordon	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fran Russell	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Viv Cutbill	HMICFRS inspection officer
Adrian Gough	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMCFRS inspection officer
Nicola Rabjohns	HMI Prisons health services inspector
Majella Pearce	HMI Prisons health services inspector
Laura Green	HMI Prisons researcher
Anna Fenton	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.

Main recommendations

The management and oversight of all backfill staff, but especially sergeants, used to cover custody should be improved to ensure they remain competent to perform the role effectively and are trained in the use of the police national computer. (2.24)
Achieved

The role of the custody inspector and the line management arrangements for custody sergeants should be reviewed to ensure effective local oversight and management of custody on a day-to-day basis. (2.25)
Achieved

The Dyfed-Powys area health boards should ensure that there is sufficient capacity in appropriate geographical locations to offer detainees prompt assessment under section 136 of the Mental Health Act 1983. (2.26)
Partially achieved

Leadership and strategy

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

Recommendations

Management information should be used effectively to plan, monitor and identify trends and interventions in custody to improve outcomes for the force and detainees. (3.10)
Not achieved

The Police and Crime Commissioner (PCC) or chief officer group should work with local authority partners at a strategic level to address the lack of local authority accommodation for children and young people refused bail at the police station. (3.11)
Partially achieved

The quality assurance process should include checking custody records against CCTV recordings and PERs and monitoring of handovers. (3.20)
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.

Recommendations

There should be clear policies and procedures for assessing and meeting the needs of female detainees. (4.8)
Partially achieved

Exercise yards should be accessible to disabled detainees. (4.9)
Partially achieved

Hearing loops should be available and staff briefed about how to use them. (4.10)
Achieved

The computerised risk assessment programme should be revised to improve its responsiveness to individual risk factors and its capacity to record accurately the full range of observations in use. (4.23)
Achieved

The CCTV system at Newtown should be upgraded to enable uninterrupted constant observations. (4.24)
Partially achieved

All custody staff should carry anti-ligature knives in the custody suite. (4.25)
Not achieved

A health care practitioner should always be consulted when a detainee describes symptoms or a history of a potentially serious health condition. (4.26)
Achieved

Staff handovers should take place in an area cleared of other staff and detainees and whenever possible, be attended by all incoming custody staff. (4.27)
Partially achieved

A pre-release risk assessment should be undertaken whenever a detainee is released and should involve discussions with the detainee about their wellbeing. (4.28)
Partially achieved

Dyfed-Powys Police should monitor the use of force and strip-searching at each custody suite by ethnicity, age, location and officers involved, identifying trends and taking appropriate action in line with ACPO guidance. (4.33)
Not achieved

There should be thorough daily and weekly maintenance checks which should include monitoring of cleanliness, natural light, temperature and call bells as well as prompt attention to faults. The recording and quality assurance of cell checks should be improved. (4.38)
Partially achieved

Detainees kept in custody overnight should be able to shower, in reasonable privacy. (4.50)
Not achieved

Detainees should not be expected to walk around the custody suite in unsuitable clothing or barefoot. (4.51)
Not achieved

Detainees held for long periods, particularly if they are vulnerable, should be allowed visits at all suites. (4.52)
Achieved

Detainees held for long periods should be offered outside exercise. (4.53)
Partially achieved

A range of reading materials should be available and routinely offered, including for those whose first language is not English. (4.54)
Partially achieved

Individual rights

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

Recommendations

Dyfed-Powys Police should develop and promote further alternative-to-custody approaches, while custody officers should ensure that the 'necessity test' for arrest is understood by all staff and meaningfully undertaken. (5.9)
Achieved

Information about detainees' rights and entitlements should always be available in a range of formats to meet specific needs. (5.17)
Partially achieved

Up-to-date copies of relevant PACE codes of practice should be available at every suite. (5.18)
Not achieved

Sufficient inspectors should be designated to undertake PACE reviews of detention, more of which should be completed in person. (5.19)
Achieved

Dyfed-Powys Police should engage with HM Courts and Tribunals Service to ensure that early court cut-off times and the lack of court availability do not result in unnecessarily long stays in custody. (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.

Recommendations

The clinical rooms should comply with environmental and infection control standards associated with NHS primary care; the environment should be clean. (6.6)
Partially achieved

Medicine cabinets should be constructed and installed to the required standards. (6.14)
Partially achieved

Custody officers should not administer prescription-only medications without a signed medical prescription. (6.15)
Achieved