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Comisiynydd Heddlu a Throseddu
Dyfed-Powys
Police and Crime Commissioner

Heddlu Police
DYFED POWYS

Custody Independent Scrutiny Panel:

Use of Force

June 27th 2024

Police and Crime Commissioner for Dyfed-Powys
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Contents

Overview, Background, Purpose and Methodology

In 2022, the National Police Chief Council (NPCC) and the Association of Police and Crime Commissioners (APCC) identified that there was limited independent scrutiny of disproportionality and custody in forces across England and Wales. Following several high-profile incidents in recent years there has been a decrease in public confidence in the treatment of the public by the police.

The APCC and the NPCC have suggested that an Independent Custody Detention Scrutiny Panel would improve transparency, increase public confidence and identify both good and poor practices.

The overall purpose of the Independent Custody Detention Scrutiny Panel is to ensure that the implementation of police detention and custody procedures in Dyfed-Powys are proportionate, lawful, and necessary.

Membership of the scrutiny panel consist of pre-existing (but not exclusive to) volunteers from:

1) Independent Custody Visitors (ICV)
2) Quality Assurance Panel (QAP)

In addition to the Panel members, the scrutiny process was accompanied and assisted by a Custody Sergeant, representation of the Assurance Team from the Office and Police Crime Commissioner (OPCC) and the Chief Inspector of custody for Dyfed-Powys Police. This was to assist with professional advice to the Panel should they have any queries in relation to:

- The processes and procedures in custody in relation to Use of Force (UoF).
- Any questions on the Electronic Forms (E-Forms) which was used to record and provide feedback for the purposes of this scrutiny.

To also aid the volunteers' understanding, prior to the meeting, the volunteers were provided with training by a Specialist Operations Trainer, who provides training to new officers and refresher training to experienced officers, to cover the processes and procedures for safely using UoF to a detainee in custody.

The cases were selected at random and supplied by the Force, focussing on UoF and Special Risk Clothing (formerly known as Anti-Harm suite) cases in custody.

The focus on UoF stems from His Majesty's Inspectorate of Constabularies (HMIC) report published in 2021 entitled *Disproportionate use of police powers – A spotlight on stop and search and the use of force*, which references under section *Forces need to improve their monitoring of how force is used to understand whether it is being used fairly:*

> *"We found that too few forces were sufficiently analysing and monitoring the data to understand how, why and on whom force was used and to what effect. Too many forces either didn't analyse force-level data, or their analysis required development – sometimes substantially so. These forces can't properly assess, or show to the public, how fairly and appropriately force is used by their officers and staff; nor can they make effective improvements in their practices, including improvements to officer and staff safety. In a smaller number of forces, we found structured force-level analysis. This led to a good understanding of how force was used, and swift action being taken where required, including improvements to personal safety training to reduce injuries.*
>
> *Our rolling programme of custody inspections, carried out jointly with Her Majesty's Inspectorate of Prisons, includes an assessment of the use of force in police custody. The findings of these inspections generally show that governance and oversight of the use of force is not good enough, and the data and information underpinning any such oversight is limited and often inaccurate. However, these inspections review CCTV footage of use of force incidents in custody, and this generally shows good efforts to de-escalate incidents. And when force is used, it is usually justified and proportionate. Overall, we expected more forces to have effective internal monitoring processes in place by this stage, and the absence of these measures needs to be addressed as a matter of urgency."*

In addition, a more recent report published in June 2024, the APCC Guidance: Preventing Deaths in Custody and Apparent Suicides Following Release From Custody specifies within this report, under section ***Custody Detention Scrutiny Panels (CDSPs),***:

"CDSPs can scrutinise areas of custody to ensure the force have appropriate measures in place to prevent deaths. This includes reviewing adverse incidents (this includes a death, or near-miss), scrutinising pre-release risk assessments, ensuring they follow College APP: Detention and Custody Risk Assessment and HMICFRS custody expectations on pre-release, and use of force incidents to ensure rationales behind the decision were clear and justified."

The report also highlights findings from the Independent Office for Police Conduct (IOPC) over the 2022/2023 that from the 23 individuals who died within custody, 11 of those had experienced UoF.

A Specialist Operations Trainer, who delivers training to police officers on UoF, gave an input to the Panel before they reviewed the selected cases. The trainer emphasised the College of Policing Authorised Professional Practice which states:

"The Criminal Law Act 1967, the Police and Criminal Evidence Act 1984 and common law apply to all uses of force by the police and require that any use of force should be 'reasonable' in the circumstances. Reasonable in these circumstances means:

- *Absolutely necessary for a purpose permitted by law; and*
- *The amount of force used must also be reasonable and proportionate (i.e., the degree of force used must be the minimum required in the circumstances to achieve the lawful objective) otherwise, it is likely that the use of force will be excessive and unlawful."*

There is also a requirement within Dyfed-Powys Police for officers to consider the National Decision Model when applying use of force which focuses on:

- Gather information and intelligence.
- Code of Ethics- sets and defines the exemplary standards of behaviour for everyone who works in policing.
- Assess threat and risk and develop a working strategy.
- Consider Powers and Policy.
- Identify options and contingencies.
- Take action and review what happened.

In addition to reviewing UoF cases, the Panel were also asked to consider Special Risk Clothing (SRC), formerly known as Anti-Rip suites or Anti-Harm suites.

SRC is the use of re-enforced material that reduces risk of detainees being able to tear clothing with the purpose of self-harm by making ligatures. The use of SRC should only be used for the purpose of reducing the risk of a detainee causing self-harm during their detention in custody and not for any other purpose. The Independent Custody Visitors Association (ICVA) have reported consistent concerns with the application of SRC specifying:

- ***The suits/clothing are recorded as being used in the absence of risk information, often with difficult detainees, by force, and have been noted as being potentially punitive.***
- ***Poor recording and practice in terms of both proportionality and justification of the use of the suits.***

Since March 2022, Dyfed-Powys Police (DPP), ICVA and the OPCC have initiated the Anti-Rip suit pilot, which allows Independent Custody Visitors (ICV) to view custody records of individuals within Dyfed-Powys custody suites who have been issued with an anti-harm suit, looking particularly at:

- ***Are the suits being issued appropriately,***
- ***Are they being removed as soon as possible,***
- ***Is there sufficient rationale for their use recorded within Custody logs.***

Since May 2023, with the integration of a new police recording database called Niche, this pilot has had to be paused. With Chief Constables encouraged to ensure that all forces implement a reportable function for the use of SRC on custody systems to allow greater scrutiny, it is recognised that Custody Scrutiny Panel can continue to monitor progress in this area.

Specific areas that the Panel focused on were dignity and respect, disproportionality, timeliness, Appropriate Adults (AA), if Special Risk Clothing or strip searches were authorised; and if so, if a rationale was provided for any of these.

Summary of Findings

In summary of the findings, the overall feedback from the Panel was positive and the Panel members were keen to highlight the challenges that custody staff have in making their risk assessments in challenging environments. The Panel assessed that the overall average rating of the 16 custody records reviewed scored 4.18 out of 5.

In relation to the positives, the Panel specified the following:

- In all cases scrutinised by the Panel, an observation level was set, (taking all risks into account and recording of the rationale recorded) and all observation levels were adhered to (page 14).
- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 23 minutes with the highest waiting time was 1 hour.
- The average time a detainee was held in custody was 19 hours and 8 minutes.
- 81% of detainees were asked about any special dietary requirements, 94% of custody records reviewed had recorded that detainees were offered food and refreshments.
- All five recorded female detainees were offered menstrual products and 81% of detainees were recorded as being offered showers and handwashing facilities.
- All detainees were given their rights either at the booking in stage or at some stage during their detainment.
- A number of the Panel members noted that the observation levels were downgraded from higher risk level grading to Level 1 appropriately during the DPs detention and that they were regularly monitored.
- Of the 16 cases reviewed, 8 required to see a HCP and there were no delays in DPs receiving a health assessment
- A rationale was provided for every SRC administered to detainees.
- Of those DPs subjected to a strip search, the Panel noted that a good rationale was provided.
- Those DPs requiring an AA, all had a rationale provided.

Where the Panel identified areas of concern or where there could be improvements, their observations were shared with the Chief Inspector of Custody and their response has been included in section 3 *Panel Observations.*

Panel Observations

Force comments were produced by Chief Inspector of Custody in Dyfed-Powys Police Jenna Jones.

Theme	Observation	Force Response
Appropriate Adult (AA)	For one individual record, the Panel member noted some confusion over the use of an AA. The initial record stated that an AA was not needed; however, one was eventually appointed but no rationale was provided. There is also no information as to when the AA was contacted or when they arrived at custody. Page 26	I have reviewed the custody record and the initial Custody Sergeant (CS) has not requested AA as he has not been able to assess properly due to level of violence. This in itself would not suggest an AA is required, a full risk assessment would need to be completed. There is an entry within the record that specifies a further care plan once the detainee has calmed. The CS also provides details of a Risk Assessment and requirement for an AA due to the detainee's ADHD/Autism and previous threats to harm. There is a further entry which states that an AA provider was contacted; however, there was no entry specifying an AA had arrived. In conclusion, I am satisfied with the detail within this record.

Gaps in recording additional requirement and rationale for support services.	There remains to be gaps in the additional requirements for detainees: Religious items- there were 3 occasions where the Panel could not ascertain whether religious items were offered or requested in any of the custody records. Page 15 Dietary requirements- there were two accounts where there was no detail recorded that this was asked to the DP. Page 11 Cell Call Bell- 9 out of the 12 records viewed could not ascertain that the DP was instructed regarding the Cell Call Bell. Page 11 Toilet pixelation- 9 out of the 12 records could not find detail that instructed the DP that the toilet area is pixelated. Page 12 Panel member noted that despite that the DP was recorded as specifying having issues with their anxiety and depression, there was no record to show that a mental health service was contacted. Page 20 Of the seven records that identified an Appropriate Adult (AA) was needed, 6 had provided a rationale. For the individual record it stated that an AA was not needed; however, one was eventually appointed but no rationale	I will address some of these individual findings as a whole with the inspectors during our performance meeting when we review this document. Toilet pixelation is now clearly printed on the walls above the toilets within the cells in every block so I am not concerned if it is recorded in the detention log. I am aware that on the whole, the Detention Escort Officers (DEO) have this discussion as a matter of course when taking detainees to cells. However, we are also reviewing Use of Force records where this may not be possible due to the level of violence. I have addressed the specific points raised in points 5 and 6 separately.

	was provided. There is also no information as to when the AA was contacted or when they arrived at custody. Page 25 However, all DPs were offered their rights and entitlements and 83% of the 12 DPS were offered Hygiene facilities, with delays only factored due to DPs violent behaviour.	
Female detainees	Of the five female detainee records reviewed under UoF, three were assigned a same sex officer and one record specified that the Panel member could not find information if the female DP was asked if they would like to speak to someone from the same sex. However, all females were recorded being offered menstrual items. Page 14	Feedback will be provided to all custody staff around this. We have seen an improvement in female officer allocation to female detainees but there are still gaps as have been seen here. This is an area Custody Services are going to be focusing on moving forward with our monthly audits. Regular messages will be sent out and the Custody Inspectors advised of the need to ensure their staff are adhering to this.
Requesting Legal Counsel	The average length of time taken for police to contact a solicitor was 55 minutes and the longest period being 4 hours and 7 minutes. Should requests for legal representation be done more expeditiously? Page 16	This can very much depend on when the ask was made, the call to request a solicitor should be made at that point; however, there are many factors that can affect this; for example, an intoxicated detainee whose behaviour is affecting the custody staff's ability to communicate and provide their rights. As this review is regarding Use of Force, I

		imagine this may have impacted on the data in this area. I am not concerned with the average length of time requests for legal representation are made.
Observational Level and Managing Risk	The Panel recorded 100% confirmation that all DP's risks were taken into account with the rationale recorded. A number of the Panel members noted that the observation levels were downgraded appropriately during the DPs detention and that they were regularly monitored. Page 18	This is excellent feedback and something we have worked hard on with the staff to get right over the last 10 months and is one of the most important factors of a detainee journey in custody. Ensuring this is managed and documented appropriately is comforting to know.
Mental Health	Panel member noted that despite that the DP was recorded as specifying having issues with their anxiety and depression, there was no record to show that a mental health service was contacted. Page 20 Of the 12 cases reviewed, 7 required to see a HCP and there were no delays in DPs receiving a health assessment. Panel members were also asked to comment on how custody staff handled MH. Panel members specified on a number of occasions that the DP's history was used to safeguard them, that this would influence the observational level and on one	Someone stating that they have anxiety and depression does not necessarily require a MH assessment. I would be interested to understand with this feedback if the panel member thought the general recording and rationale on this record was sufficient. There being no delays in seeing a HCP is pleasing to see; we know at present there are challenges with HCP cover across the force; so to ensure those that require HCP support are receiving it, is excellent feedback. If someone is in MH crisis in custody, it is our responsibility to ensure that person is treated with respect and

	occasion, MH was immediately identified with the MH team personnel present within 3 hours of being requested. Page 25	dignity and provided with the support needed. The feedback suggests this was a good example of that.
Special Risk Clothing (SRC)	Of the custody records that wore an SRC, a full rationale was provided and there were continual risk assessments conducted. It also shows that there was evidence of de-escalation, distraction items or other methods used to reduce the detainees risk level. Page 21 However, for one of the two DPs, the records did not show that SRC was discussed during handover, SRC was removed at the earliest opportunity and for both SRC records, there was no evidence to show that SRC was removed prior to interview. The Panel member referenced that the SRC rationale appears to be missing from the record. From the additional SRC records reviewed: - All DPs engaged with the risk questions. - All DPs were assessed at risk of self-harm. - Rationale was provided for the use of SRC for all four DPs.	Very encouraging feedback around use of SRC. I have reviewed this log and have found some other issues which I will raise with the Inspector to address with individuals. I have located the entry which states Custody Greys were provided for Processing and Interview. There is rationale around the reasoning for SRC and a Mental Health Assessment carried out in the cell due to the concerns around the DP's mental wellbeing. I am satisfied with the rationale; however, the inspector review was missing as was the risk management through the use of care plans. All bullet points raised are noted and in the main, I am pleased with the positive feedback.

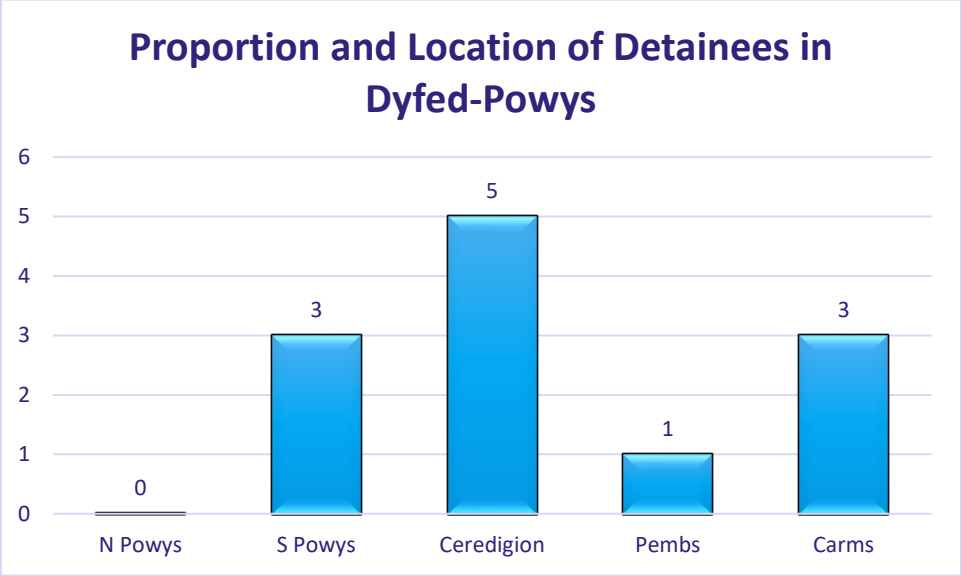
	- One DP had their clothes removed by force and they were continually monitored as part of the risk assessment. - One DP did not have a record suggesting that they were given a distraction item or other method of reducing the risk level. The other three had. - Only two records show SRC being discussed during handover. Page 31	
Children in Custody	Of the two custody records involving juvenile DPs, both were held overnight due to the domestic offences associated with their family members; however, for neither record was their alternative care sought. Page 27	I have viewed both records individually. The first record reviewed shows in the initial write up that the officers tried to identify a safe space for the juvenile to go but there was no place available. The juvenile DP had been particularly violent and was intoxicated. The juvenile's family were victims and witnesses to the incident, so it would not be appropriate for safeguarding reasons for the juvenile DP to return home. I have no concerns with this record and I think the recording and rationale provided was very good. The second record reviewed showed that there was no suitable accommodation and the incident would need to be dealt with during the custody period. The juvenile was

		violent in custody and there would not have been an option to place anywhere else due to this extreme behaviour. Also intoxicated and was placed on Level 3 observations. No issues with this one.

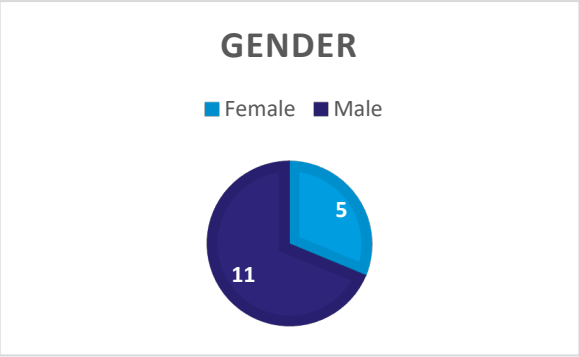
Custody Record Review Findings

The data below outlines the results of the feedback forms completed by the Panel members which was analysed to identify the positives and areas requiring improvement in each specific area of custody with the focus of Use of Force (UoF).

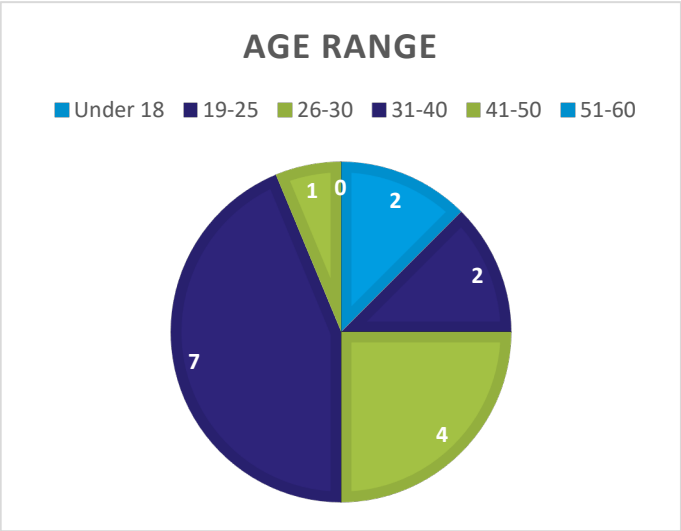
Custody Suites



Gender



- 58% of detainees recorded were male, in comparison to 42% female.
- There were no other genders recorded.



Age

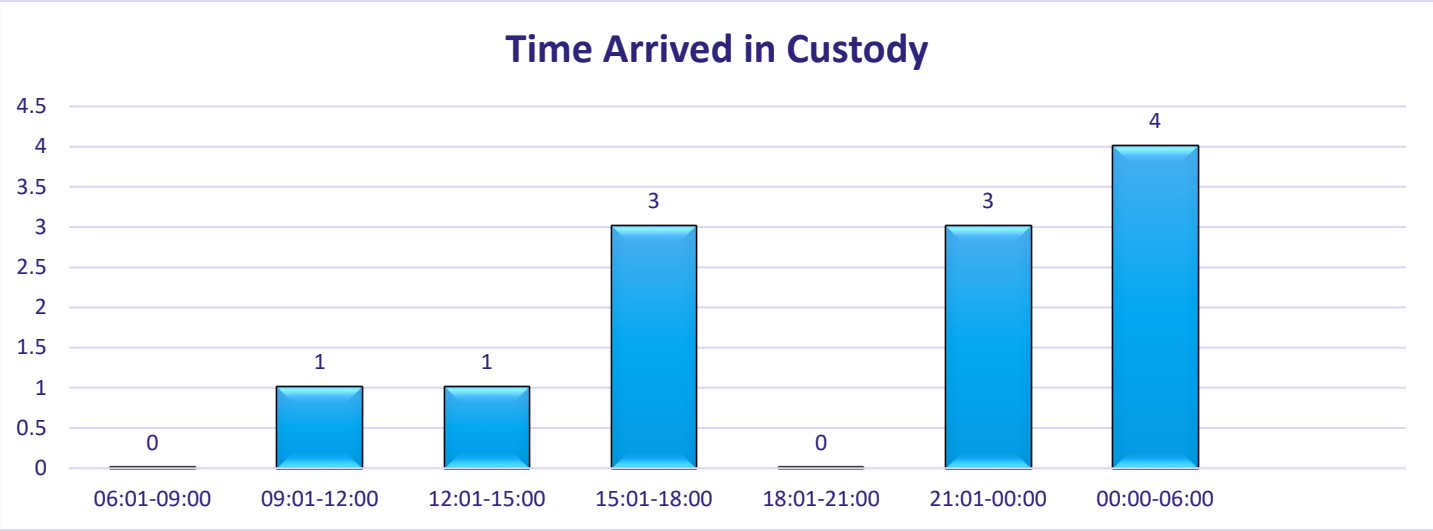
Of the 16 UoF custody records viewed by the Panel:

- Two of those were under 18.
- Majority were in the age range of 31-40 years old.
- There were no records of a detainee recorded from 51-60.

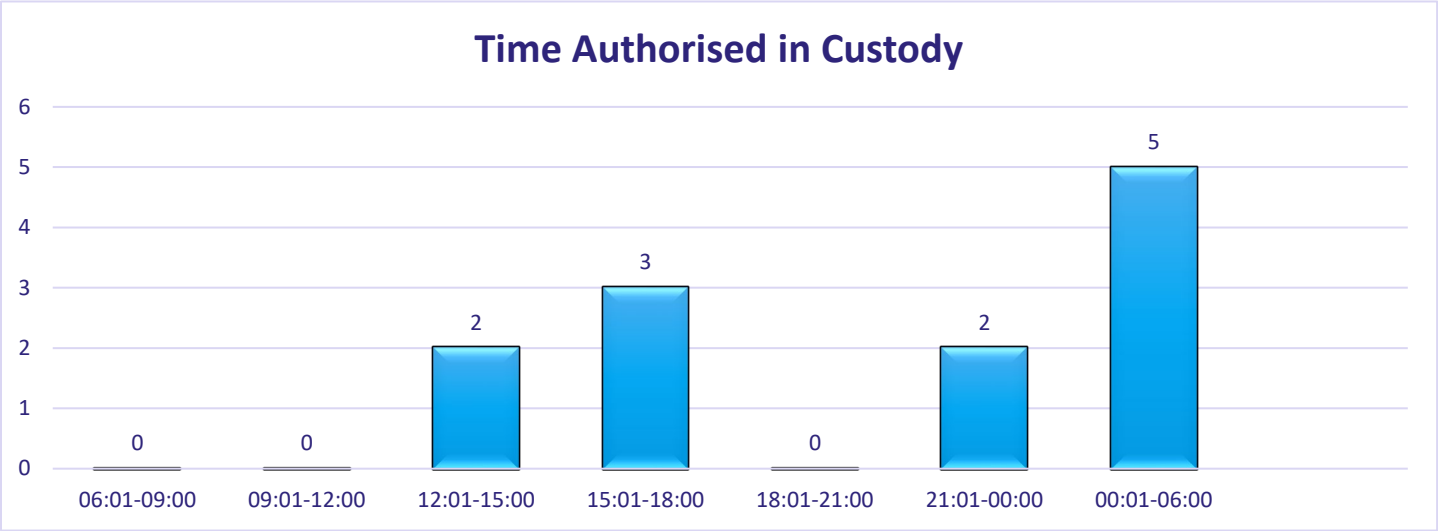
Ethnicity

- One detainee was recorded as Asian ethnicity.
- The others were either defined as White British or White North European.

Times Arrived in Custody



Times authorised into Custody

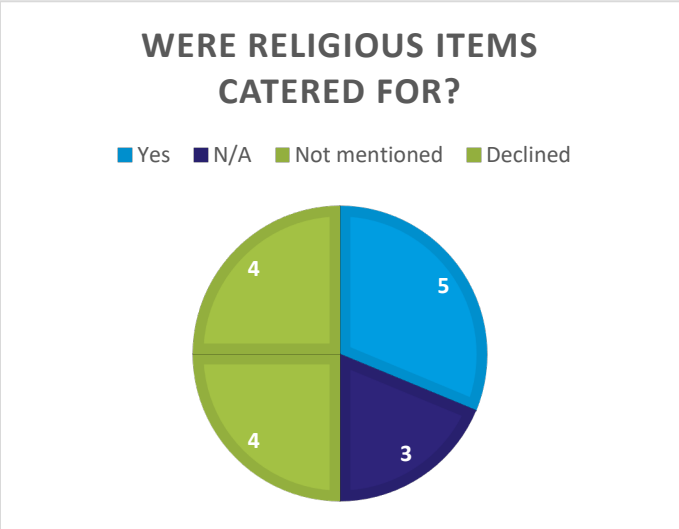


Time lapsed from arrival to detention authorised

- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 23 minutes.
- The highest waiting time was 1 hour.
- The fastest time for a detained person (DP) to have their detention authorised was 1 minute.
- The Panel advised that rationale was recorded on one occasion due to an assault on a police officer, whilst another delay was due to the closure of a local custody, which required an hour's journey for the detainee to be processed at the nearest custody suite.

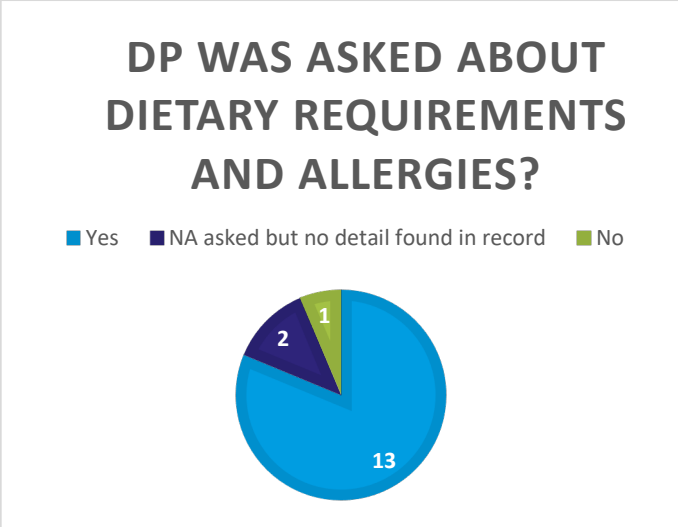
Total Time in Detention

- The average time a detainee was held in custody was 19 hours and 8 minutes.
- The longest time a DP was held in custody was 2 days 17 hours and 2 minutes.
- In contrast, the shortest time a DP was held in custody was 8 hours and 36 minutes.



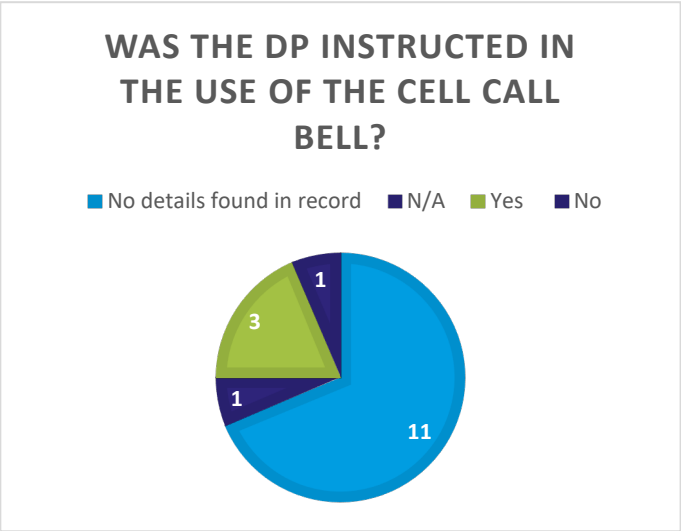
Religious Requirements

- Out of the 16 records, there were 3 occasions where the Panel could not ascertain whether religious items were offered or requested in any of the custody records reviewed.



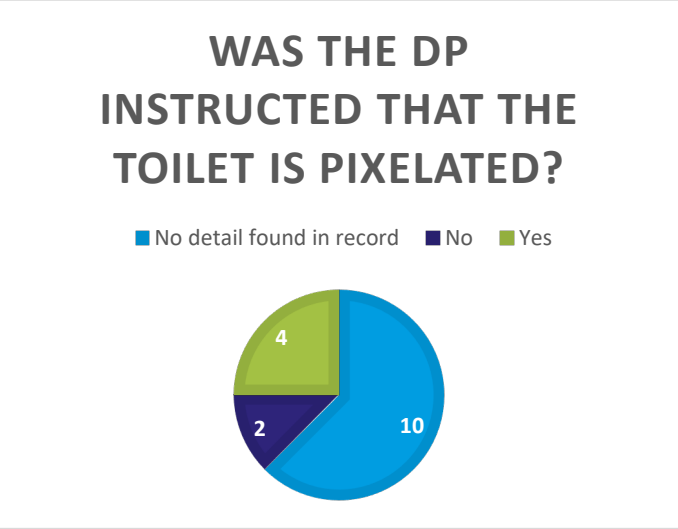
Special Dietary Requirements

- 81% of detainees were asked if they had any special dietary requirements in contrast to two accounts where there was no detail recorded that this was asked to the DP.



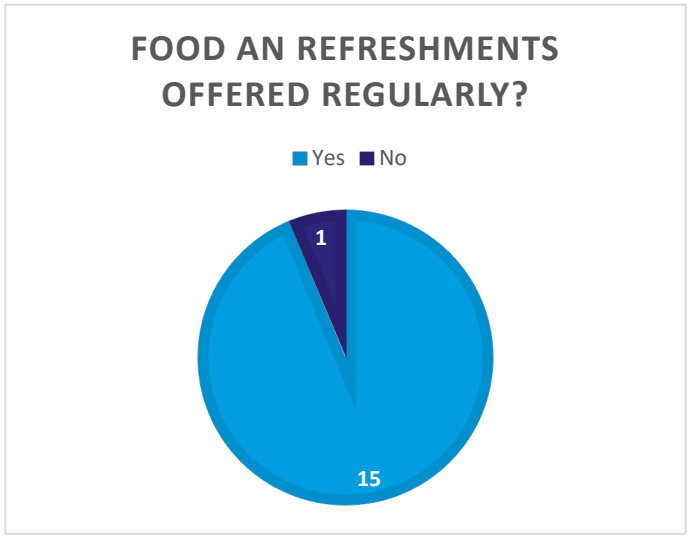
Cell Call Bell

•The Panel noted that 69% could not ascertain on the record that detainees were instructed regarding the call bell located within their custody cell. In contrast only 19% recorded that detainees had been instructed.



Toilet pixelation

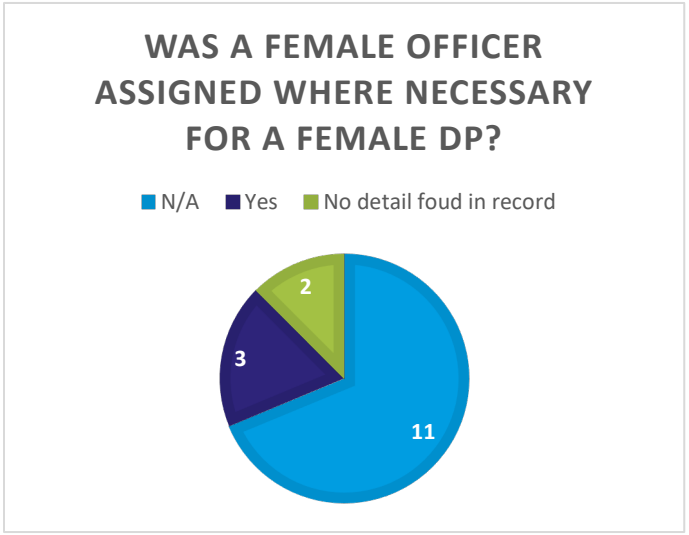
• 62% of the Panel could not find any information that specified that toilet pixelation had been advised to the Detained Person (DP) during their detention.
• 25% recorded that they had and 13% recorded that they had not.



Food Refreshments Offered

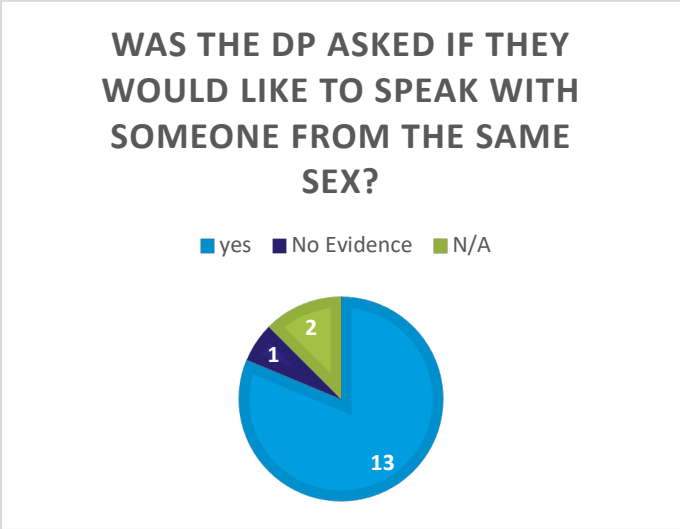
- 94% of custody records reviewed had recorded that detainees were offered food and refreshments.

Female Detainees

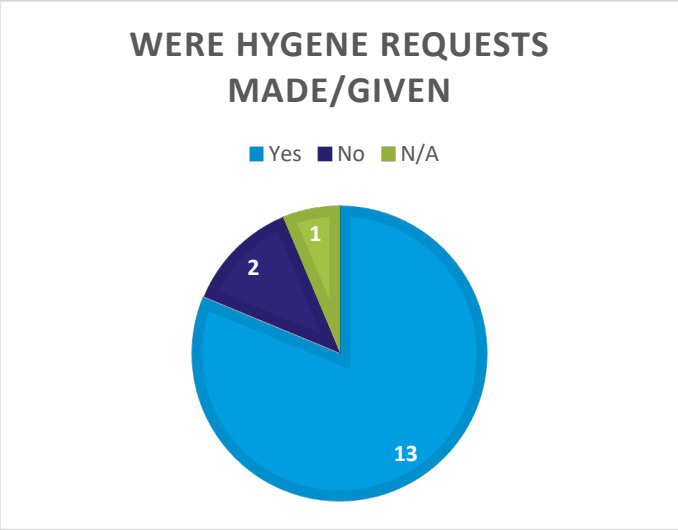


Female Officer Assigned for a Female Juvenile DP

- Of the five female detainee records reviewed, three were assigned a same sex officer.
- All females were offered menstrual products.
- Only one record whereby it could not be found if the female DP was asked if they would like to speak to someone from the same sex.

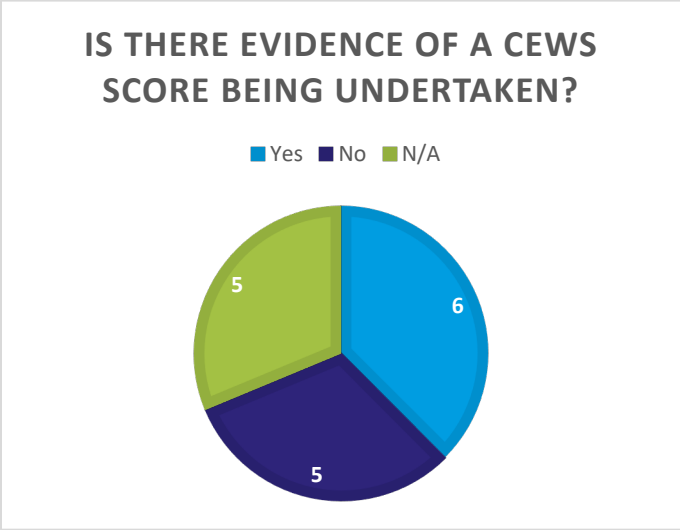


Hygiene Requests



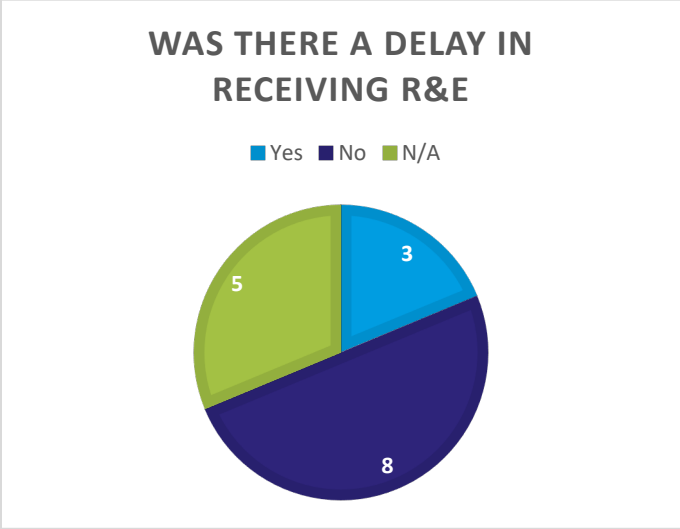
- 81% of detainees were recorded as being offered showers and handwashing facilities.
- In relation to comments regarding hygiene, one Panel member noted that toilet paper did not appear to have been supplied until much later into the detention where it was recorded that the detainee had requested it.
- Others noted that DPs were offered all entitlements and some were delayed access to these due to their violent behaviour.

Custody Early Warning Score (CEWS)

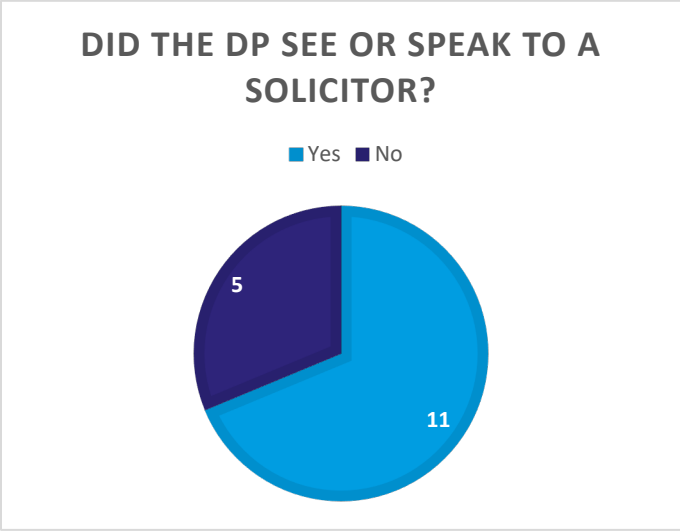


- Custody Early Warning Score (CEWS) system has been added to the normal standardised police risk assessment process to identify detainee morbidity and mortality risk.

Rights Entitlement



- All detainees were given their rights either at the booking in stage or at some stage during their detainment.
- This pie chart illustrates that 19% of detainees experienced delays in being offered their Rights and Entitlement booklet; however, it is important to note that this booklet is optional and DPs have the right to decline this option of having the booklet whilst detained.

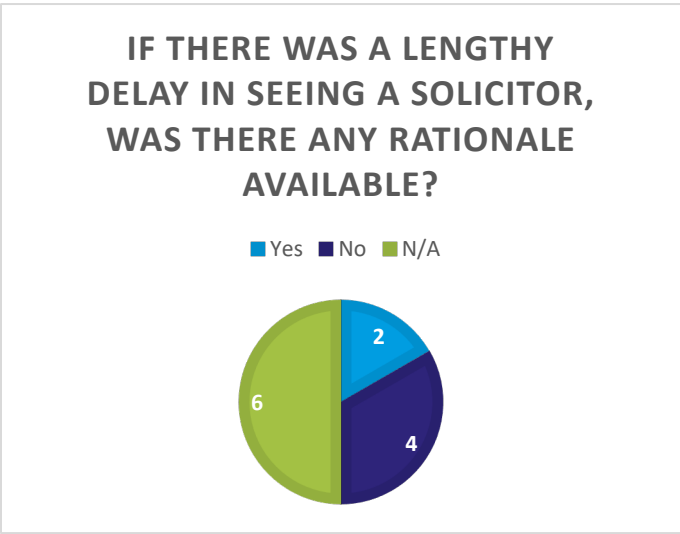


How long, after detention authorised, did the DP request a solicitor?

- The average time for a detainee took to request a solicitor was 3 hour and 8 minutes.
- In 5 of the cases, the DP made the request for a solicitor within 25 minutes.
- The longest period for a DP to request a solicitor was 12 hours and 30 minutes.
- 69% of detainees saw or spoke with a solicitor during their detainment.

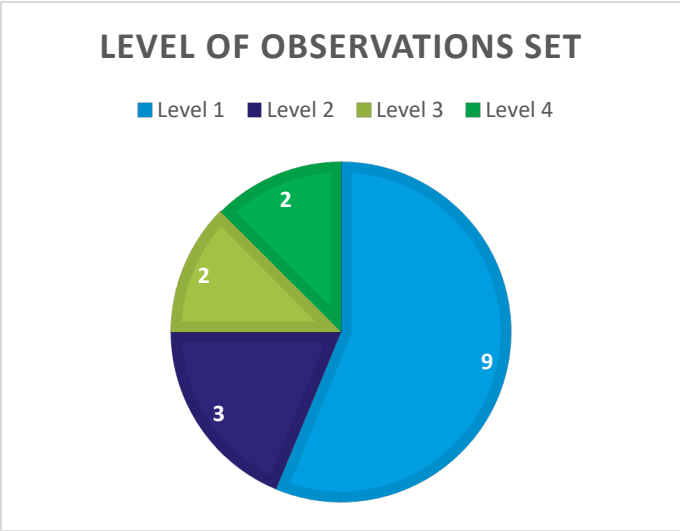
The length of time taken for police to contact a solicitor

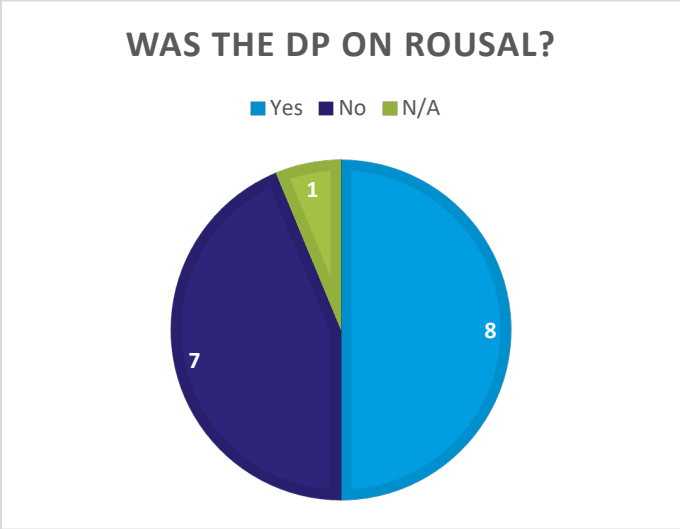
- The average time taken was 1 hour 26 minutes for police to contact an on-duty solicitor.
- The longest period of time was 6 hours and 30 minutes.
- The shortest was immediately after being requested.



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

- The average time for solicitor to arrive was 11 hours and 20 minutes.
- There were two occasions where a solicitor arrived after 14 hours of the DP being detained.
- The shortest time noted was 40 minutes.
- The Panel had noted only on two occasions had a rationale been provided to explain the reason for the delay. On four other occasions there was no rationale found.
- The Panel also noted that on one occasion, the delay was explained due to the DP's violent behaviour and requirement for medical treatment. There were two instances whereby the solicitor requested was unavailable and the DP was asked if they would like an on-duty solicitor instead.



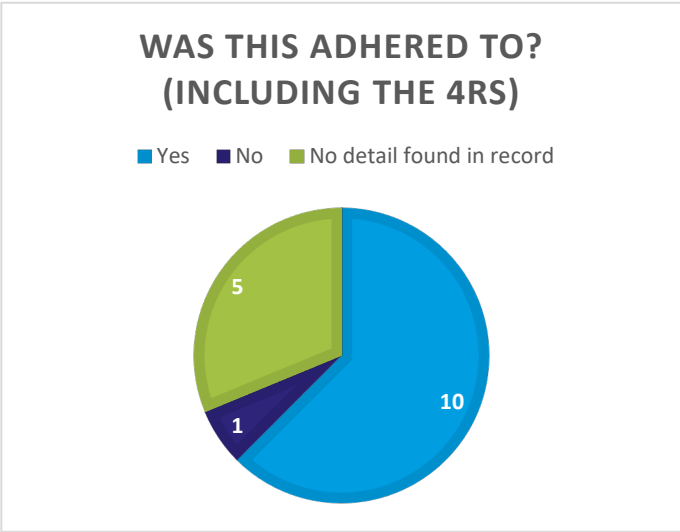


Observation level

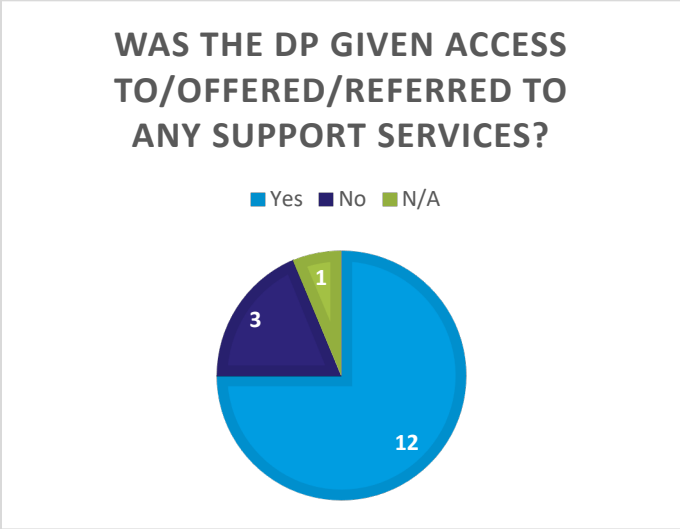
- The risk level is judged on 4 levels.
- Level 1 General (at least once every hour)
- Level 2 Intermittent (every 30 minutes)
- Level 3 Constant (constant observation CCTV and accessible at all times)
- Level 4 Close Proximity (physically supervised in close proximity).

- The Panel recorded 100% confirmation that all DP's risks were taken into account with the rationale recorded. Level 4 and Level 1 were recorded as the most prevalent risk grading with 43% each.
- 63% of observation levels were deemed to have been adhered to in comparison to 1 that had not. In 5 of the cases, the panel could not find a record.

- A number of the Panel members noted that the observation levels were downgraded from higher risk level grading to Level 1 appropriately during the DPs detention and that they were regularly monitored.



Support Services



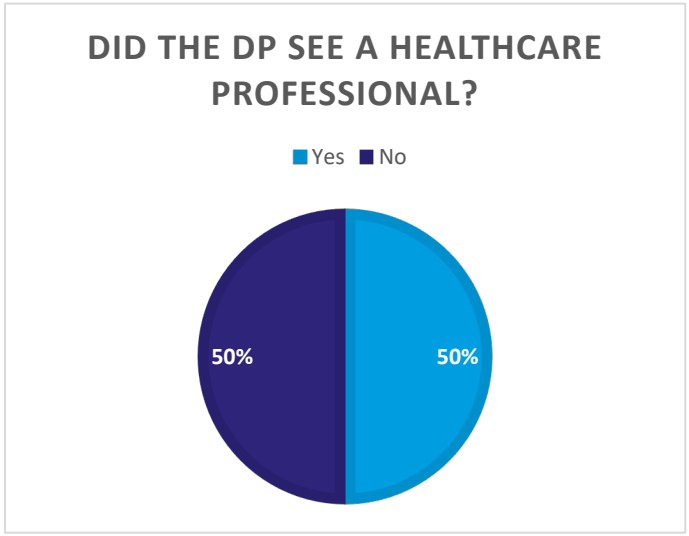
- 75% of DPs were offered support services, 19% were not.
- Of those 3 that were not provided support services, in one of the cases, a Panel member noted that despite that the DP was recorded as specifying having issues with their anxiety and depression, there was no record to show that a mental health service was contacted.
- The Panel noted the following type of services being offered were New Pathways, Child and Adolescent Mental Health Services (CAMHS) and Healthcare Professionals (HCP).

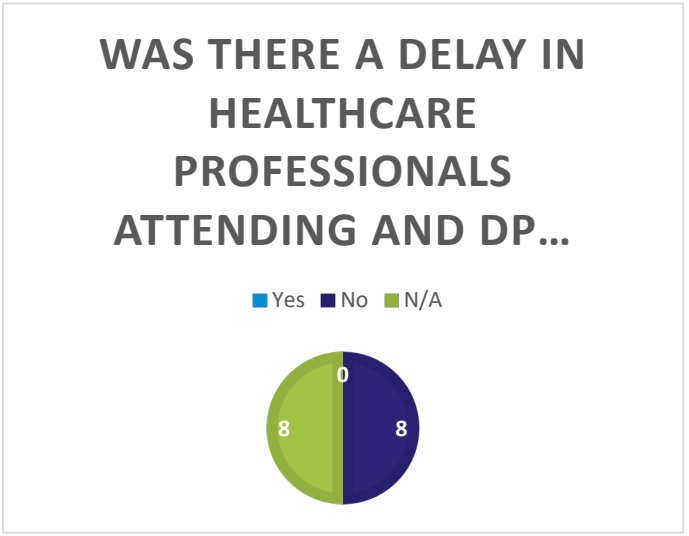
Healthcare Professional (HCP) and Special Risk Clothing (SRC) *formerly known as Anti-Rip Suites*

Reason for Rating	Follow Up Action
Drop down in use, full rationale for use of suit, which is both justifiable and proportionate to risk posed.	No further action required at this point.
Suit removed as soon as practicable.	
Clear de-escalation, distraction items etc. used to mitigate risk of detainee DSH.	
Little or unlclear justification for the use of the suit.	Advice/further training given to custody staff.
Insuffcient information to determine the proportionality of the use of the suit.	
Detainee left in suit for elongated periods of time.	
Suit drop down used but no further information.	Further exploration required as to use/rationale. Cases to be raised with custody inspector.
Suit used in absence of risk information but no other rationale.	
Suit used by force with no further information.	
Drop down not used, information on suit discovered as part of routine CRR by ICVs	

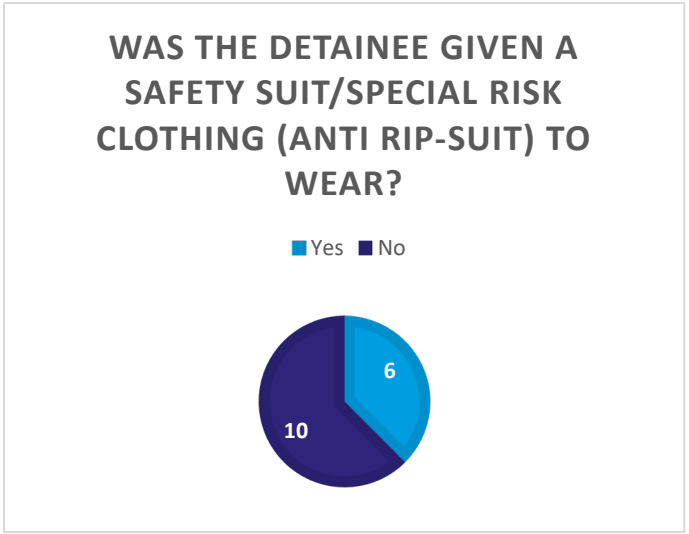
Healthcare professional (HCP)

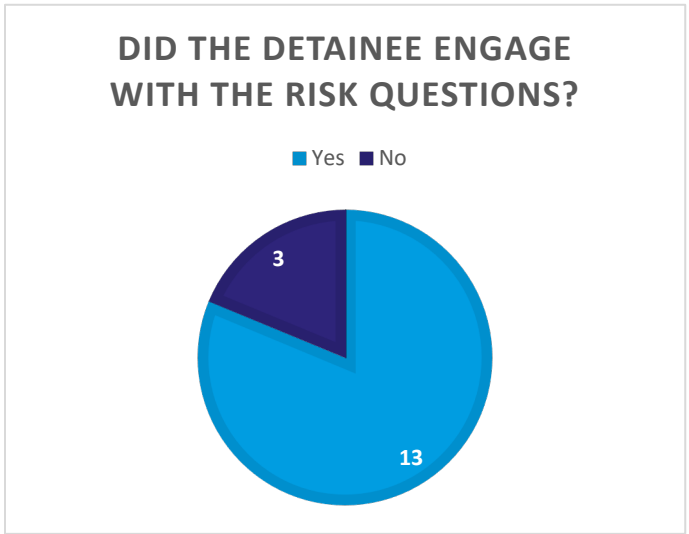
- Of the 16 cases reviewed, 8 required to see a HCP and there were no delays in DPs receiving a health assessment.

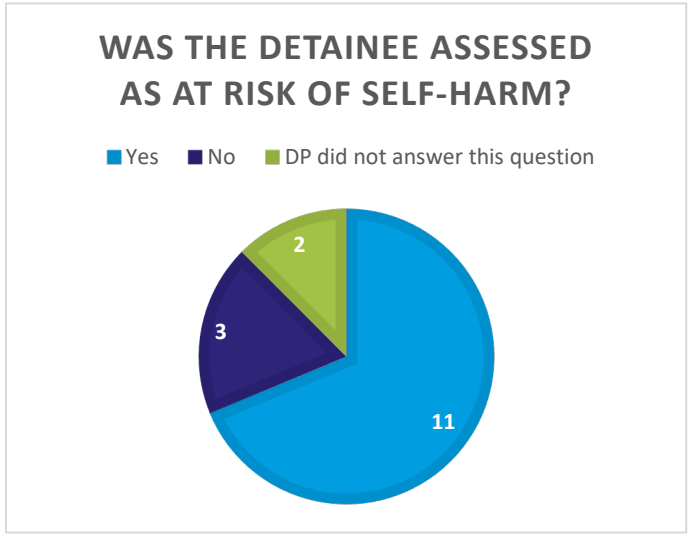




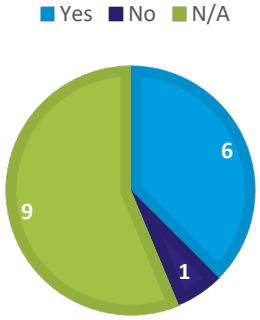
Special Risk Clothing and Use of Force



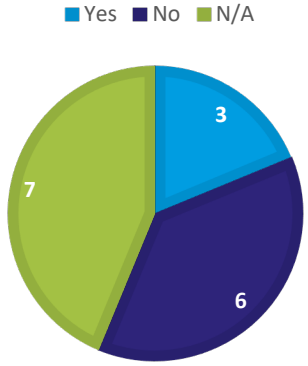




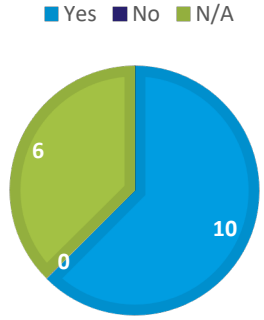
WHERE A SUIT WAS PROVIDED HAS A RATIONALE BEEN PROVIDED?



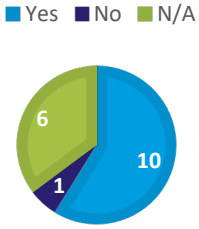
WAS CLOTHING REMOVED BY FORCE?



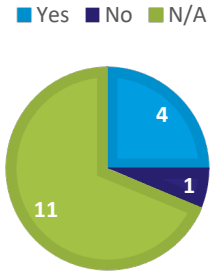
IF CLOTHING WAS REMOVED, WERE THERE CONTINUING RISK ASSESSMENTS?



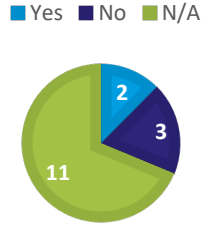
DOES THE RECORD CONTAIN EVIDENCE OF DE-ESCALATION, DISTRACTION ITEMS OR OTHER METHODS OF REDUCING THE DETAINEES RISK LEVEL?



DOES THE RECORD CONTAIN EVIDENCE OF THE SPECIAL RISK CLOTHING BEING DISCUSSED IN STAFF HANDOVERS?



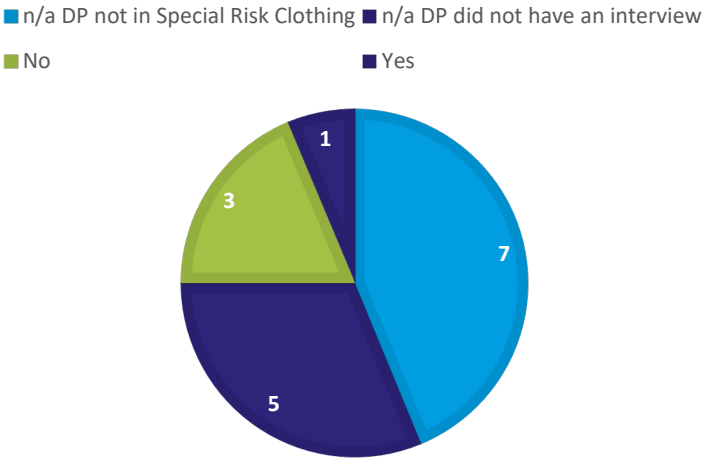
DOES THE RECORD CONTAIN EVIDENCE OF THE SPECIAL RISK CLOTHING/ANTI-RIP SUIT BEING REMOVED AT THE EARLIEST OPPORTUNITY?

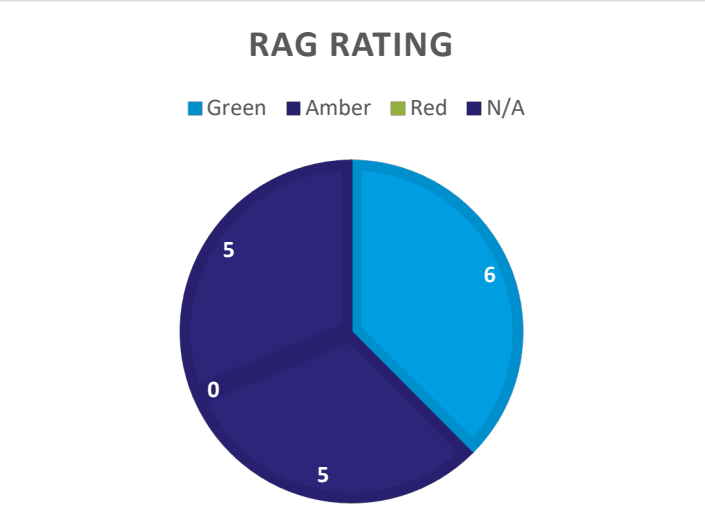


Overall, the Panel noted that:

Of those six cases, that wore SRC:

a) All appropriate action had been taken on time and at the correct level.

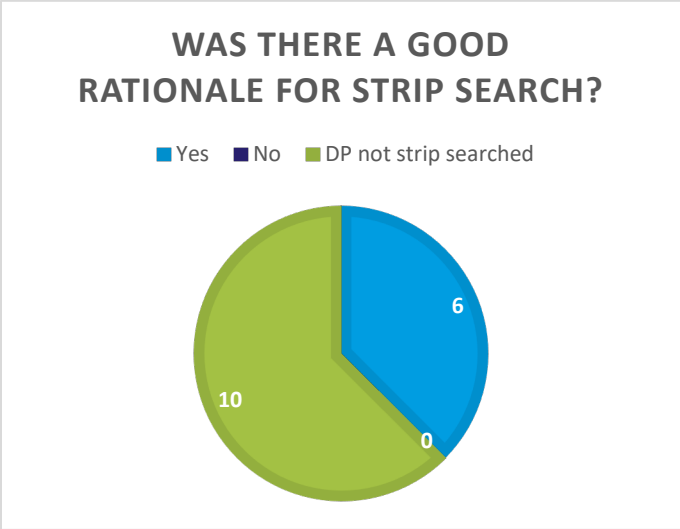




b) Records are well maintained and kept up to date.
c) All DPs engaged with the risk questions.
d) All DPs were assessed at risk of self-harm.
e) Rationale was provided for the use of SRC for all six DPs.
f) Of the three DPs that had their clothes removed by force, they were all continually monitored as part of the risk assessment.
g) One DP did not have a record suggesting that they were given a distraction item or other method of reducing the risk level. The other 5 had.
h) Only four records show SRC being discussed during handover.
i) The Panel noted, under very difficult circumstances, custody staff have responded well.
j) From the two instances where SRC was used, they were not removed before interview.
k) There was a good rationale and explanation provided for one of the DP's subjected to SRC, the other record appeared to be missing; however, it was noted that for this specific instance, violence was noted as a feature of the DP's behaviour on arrest and again on admittance to Custody.

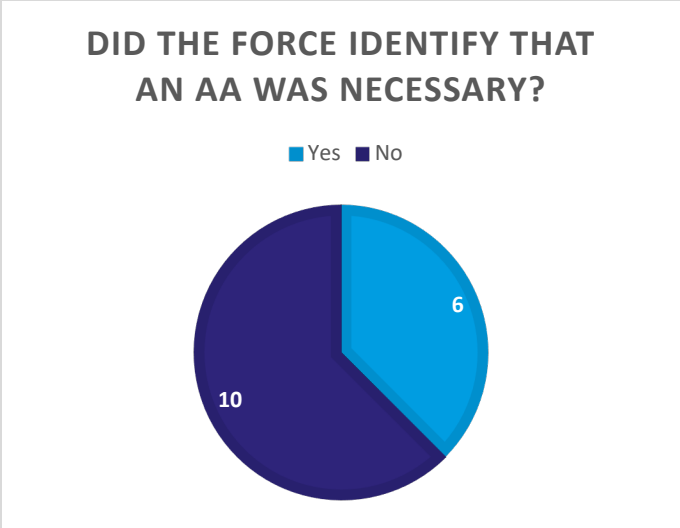
- The Panel had the following comments regarding RAG:

a) The DP was well looked after. There were no notes to suggest any concern that DP was in any harm while in custody. There was a good risk assessment which included DP's vulnerabilities involving self-harm or mental health.
b) SRC rationale appears to be missing from the record.



Strip Search

- Of those DPs subjected to a strip search, the Panel noted that a good rationale was provided. One rationale specified, whilst no SRC was required, the DP was stripped searched later as it was noted during the DP's telephone call, that they had tablets concealed on their person.



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

- The Panel were asked for their observations, in relation to how custody staff approached MH concerns in custody. The Panel noted:

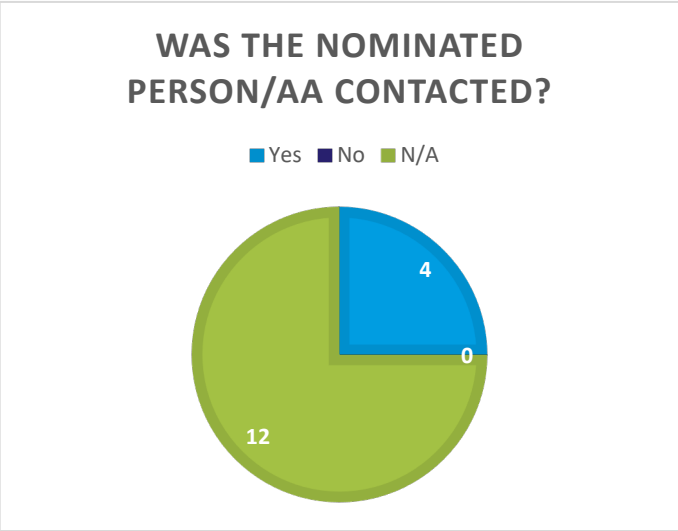
a) Custody staff were aware of DP's history and used this to safeguard them during their detention.

b) DP was looked after by the custody team, with observation levels managed appropriately.

c) MH concerns were identified immediately and MH team personnel were present within 3 hours of being requested.

- Of the six records that identified an AA was needed, 6 had provided a rationale. For one individual record, the Panel member noted some confusion over the use of an AA. The initial record stated that an AA was not needed; however, one was eventually appointed but no rationale was provided. There is also no information as to when the AA was contacted or when they arrived at custody.

- The longest period of time for a detention officer to contact an AA was 4 hours and 30 minutes with the second longest being 3 hours. In contrast, the shortest period of time was 33 minutes.

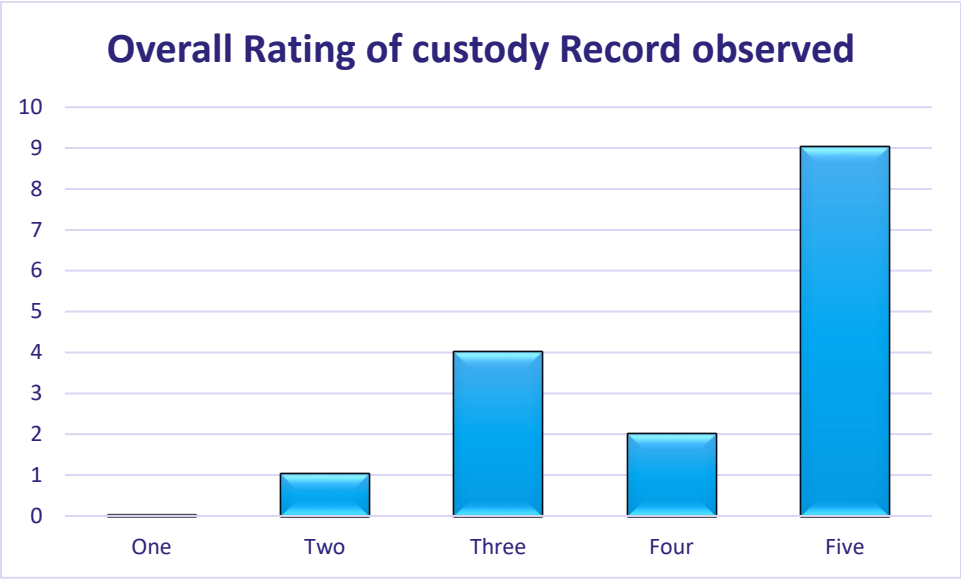


• The average time for a DP to have first contact with an AA was 5hrs and 29 minutes.
• The Panel noted that rationale for the delay of an AA arriving was recorded for 3 of the 4 records.
• The Panel raised the following comments regarding AA provision:
a) The nominated Parent could not be AA as they were the victim. The other AA was sought for the morning.
b) No rationale recorded or times contacted AA.
c) Initial violence and refusal to engage was the reason for the delay.

Children in Custody

- Of the two juvenile detainees, The Panel noted:
  a) Both juveniles were detained overnight with one being charged and the other was not.
  b) The rationale for detaining both juvenile DPs overnight were domestic abuse related, where the victims were family members.
  c) Alternative care was not sought for either.
  d) The Children in Custody checklist was used in both circumstances.
  e) It was advised that a family friend was sought as an AA for one of the juvenile DP, but were unable to attend until the following morning.

Overall Rating



- The Panel were asked to give a scoring out of 5 at the end of each custody record, with the guidance that from 1 needing improvement to 5 being outstanding.
- The overall average rating the Panel scored for Use of Force out of the 16 custody records reviewed was 4.18.