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Comisiynydd Heddlu a Throseddu
Dyfed-Powys
Police and Crime Commissioner



Heddlu Police
**DYFED
POWYS**

March 6th 2024

Police and Crime Commissioner for Dyfed-Powys
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Custody Independent
Scrutiny Panel:
**Children in
Custody**

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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, a Healthcare Professional (HCP), 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 and/or healthcare;

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- 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 Custody Sergeant that covered the processes and procedures for administering a detainee in custody.

The cases were selected at random by the OPCC and supplied by the Force, focussing on juvenile cases in custody.

The focus on juvenile cases stems from sections 10 and 11 of the Children Act 2004, which places a duty on police to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Under section 1(8)(h) of the Police Reform and Social Responsibility Act 2011, the Police and Crime Commissioner (PCC) must hold the Chief Constable to account for the exercise of the latter's duties in relation to safeguarding children under sections 10 and 11 of the Children Act 2004.

Under the Police and Criminal Evidence Act 1984 (PACE), the detention of a child (who has not been arrested on a warrant or for breach of bail) after charge is permissible only where exceptional circumstances prevent movement (such as extreme weather conditions) or where the child is deemed to pose a risk of serious harm to the public between being charged and appearing at court and no Local Authority secure accommodation is available. According to the College of Policing:

"Officers must take into account the age of a child or young person when deciding whether any of the PACE Code G(opens an external website in the same tab) statutory grounds for arrest apply. They should pay particular

regard to the timing of any necessary arrests of children and young people and ensure that they are detained for no longer than needed in accordance with PACE Code C, paragraph 1.1(opens an external website in the same tab). Officers should avoid holding children overnight in police cells unless absolutely necessary.”

In the Independent Custody Observers Pilot review of custody records, it identified instances of children being detained inappropriately, that an improvement of recording rationale for detaining children overnight needed improving and the need to engage with relevant agencies around deficits in the provision of alternative accommodation were also required.

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

In summary of the findings, the overall feedback from the Panel was positive and the Panel members were keen to highlight the good work evidenced within the custody records reviewed. However, there were several concerns raised by the panel and these concerns centred on the quality and frequency of the risk assessments/care plans being completed.

The Panel assessed that the overall average rating of the 14 custody records reviewed was 3.56 out 5.

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

- Average time between arrival at custody and detention authorised was 29 minutes (Page 7)
- Female officer assigned for all female juvenile detainees (page 10).
- Risk Assessment gradings found to be at the appropriate levels (Page 18).
- *The Panel noted that in all cases, the Force had identified that an Appropriate Adult was required (Page 20).*

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- Appropriate Adults contacted promptly and any delays in attendances were recorded.
 - Children in Custody Checklist utilised for all juvenile detainees (*page 22*).
 - All juvenile detainees were given their rights either at the booking in stage or at some stage during their detainment.
(Page 15).

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 to *Section 2 Panel Observations*.

Panel Observations

Theme	Observation	Force Response
Time held in custody	<p>The following aspects regarding a juvenile length of detention were made:</p> <ul style="list-style-type: none"> -_No rationale provided for any delay in authorising any of the juvenile detainees. <i>(Page 11)</i> -The average time taken for police to contact an on-duty solicitor was 1 hour and 48 minutes, with the average time for solicitor to arrive being 8 hours and 14 minutes. There were also two occasions where a solicitor arrived after 15 hours of the juvenile being detained.<i>(Page 14)</i> -Out of the 14 cases reviewed, the average time a juvenile was held in custody was 12 hours and 21 minutes. 57% of juveniles were detained overnight, with 50% not charged and 43% had not sought alternative care. <i>(Page 11)</i> 	<ol style="list-style-type: none"> 1. Delays in detention being authorised are being closely monitored through the Monthly Custody Performance meeting where there is now a 100% Quality Assurance (QA) of Children in Custody. Children should be prioritised when attending custody desk area being cleared. I would like to see the average time reduced from the findings and will monitor this closely. 2. Solicitor contact should be done at the nearest opportunity, 1hr and 48 minutes would appear a lengthy time but this could be affected by one very late request. This will also be affected if the child is brought in during the evening hours the solicitor request may be made some time after booking in. This is being monitored in the new QA for Children in Custody. 3. The force monitor the average length of time a juvenile has been kept in Custody. From QA processes I am satisfied that we are releasing Child in Custody (CiC) as soon as possible with

		<p>many being in under the 6 hour period. However there will be occasions and offences which require the child to remain in Custody for a longer period of time. The welfare of that child is the utmost importance.</p>
<p>Inconsistency with the data recording within Custody Records</p>	<p>The Panel were either unable to locate or specified that there was no rationale provided for:</p> <ul style="list-style-type: none"> - any delay in authorising any of the juvenile detained person (DP) (Page 11) -77% of the Panel could not ascertain on the record that juvenile DP were instructed regarding the call bell in the cell. (Page 12) -77% of the Panel could not find any information that specified that toilet pixelation had been advised to the juvenile DP. (Page 12) -No Panel member could ascertain whether religious items were offered. (Page 11) -There was no reference as to whether refreshments were offered. (Page 12) - In the circumstances that there was a delay in a solicitor visiting, 33% had provided a rationale; whereas 67% had provided no rationale observable to the Panel on the custody record. (Page 14 & 15). <p>With the Force almost reaching a year under the new computer software</p>	<ol style="list-style-type: none"> 1. As above, delay in authorising will be monitored and any child should be prioritised. If the Custody Sergeant (Sgt) is in the process of booking someone in, then this should be recorded on the child's custody record. This will be monitored moving forward. 2. Call bell will be explained to every detainee by the Custody Sgt and the Detention Escort Officer (DEO); however, the issue is not recording this in the log. This is a continual factor being raised, consistency in recording within the detention log. However, I am confident this is taking place. 3. Religious items – I will discuss with the Custody Inspectors to ensure this is being covered with all detainees and recorded. 4. This should be covered within the DEO detention logs. I will ensure this is fed back through Custody Inspectors. 5. I will look at the rationale around any delay in a solicitor attendance; however, on many occasions

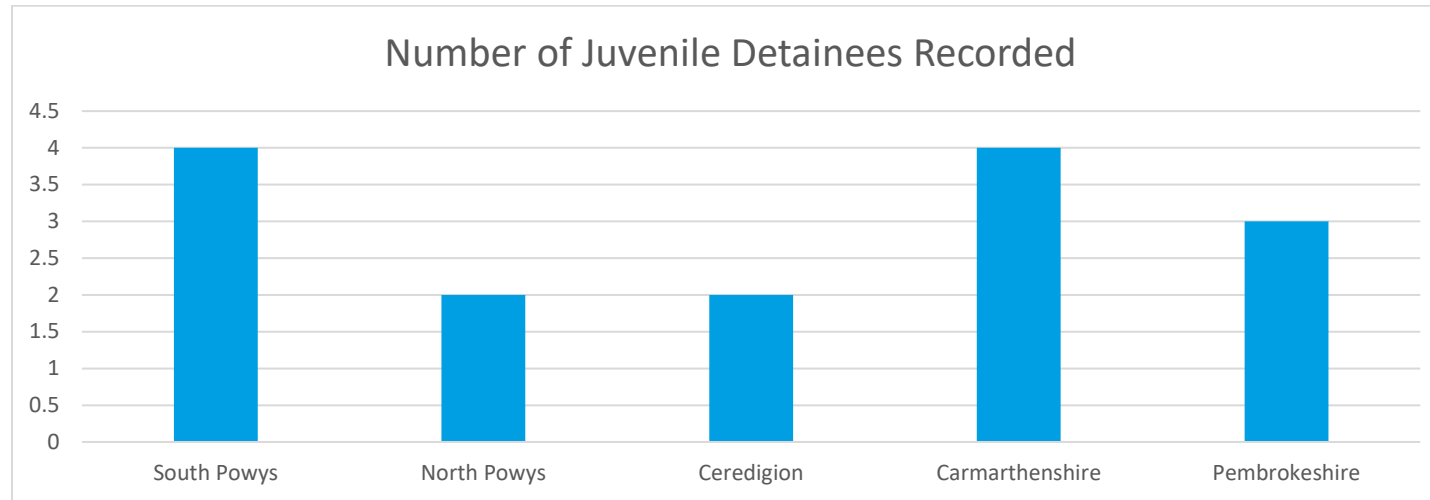
	<p>Niche, is the Force ensuring a more standardised approach of inputting information into custody records amongst the custody staff?</p>	<p>where a solicitor has been requested early the investigation team may not be ready for interview and a time slot will have been booked. This would not constitute a delay.</p> <p>6. QA processes are in place now to monitor the inputting of information. It is clear there has been a drop off in the information inputted with the new system and improvements are needed. This is being reiterated to all Custody staff and monitored closely through weekly and monthly QA processes. We are seeing improvements in the last 5 months, but we need to see more consistency.</p>
<p>Female juvenile detainees</p>	<p>There were three female juvenile DPs out of the 14 cases reviewed. All three were assigned a female officer.</p> <p>However, with regards to menstrual products, only two female DPs were recorded as being offered; whereas there was no record specified for the other. (<i>Page 9</i>)</p> <p>Does the Force monitor hygiene products for detainees; specifically for female detainees?</p>	<p>This is positive that all the female detainees were allocated a female officer.</p> <p>Menstrual products will be offered to all females and we are seeing an increase in this within the records. However, this comes down to consistency again, I will ensure this is fed back to the Custody Sgts/DEO's.</p>
<p>Children in Custody Checklist</p>	<p>The Panel are seeking clarification on whether the Children in Custody checklist contains 23 questions as</p>	<p>The 23 point checklist is the standard checklist across the force that should be used.</p>

	<p>standard or whether this depends on the offence charged towards the DP? (<u>Page 23</u>)</p>	<p>This had previously been a 18 point checklist.</p> <p>The use of the 23 point checklist is monitored monthly and was sent out again to all staff and discussed in the Custody Performance meeting following observations that Powys had been using the 18 point checklist. It was identified that this was cover Custody Sgts from response but none the less they should all be aware.</p>
<p>Support Services</p>	<p>Despite the Panel observing that 85% of juvenile DPs were offered support services, there were issues mentioned in access to Local Authority/Social Services. (<u>Page 22</u>)</p>	<p>Noted and will feed this back to the lead for Safeguarding Chief Inspector Briggs.</p>

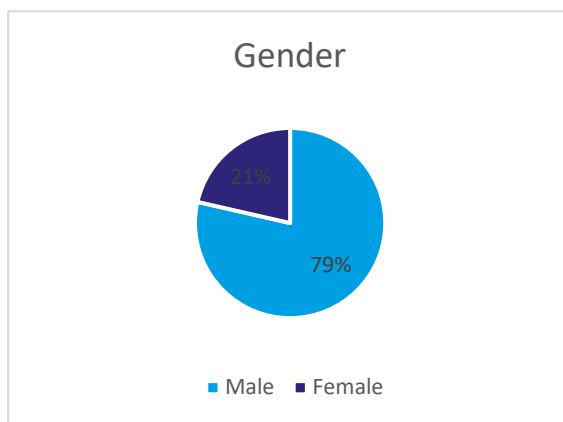
Custody Record Review Findings

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 a custody record.

Custody Suites



Gender



- 79% of cases reviewed consisted of male juveniles in comparison to 21% Female.
- There were no other genders recorded.

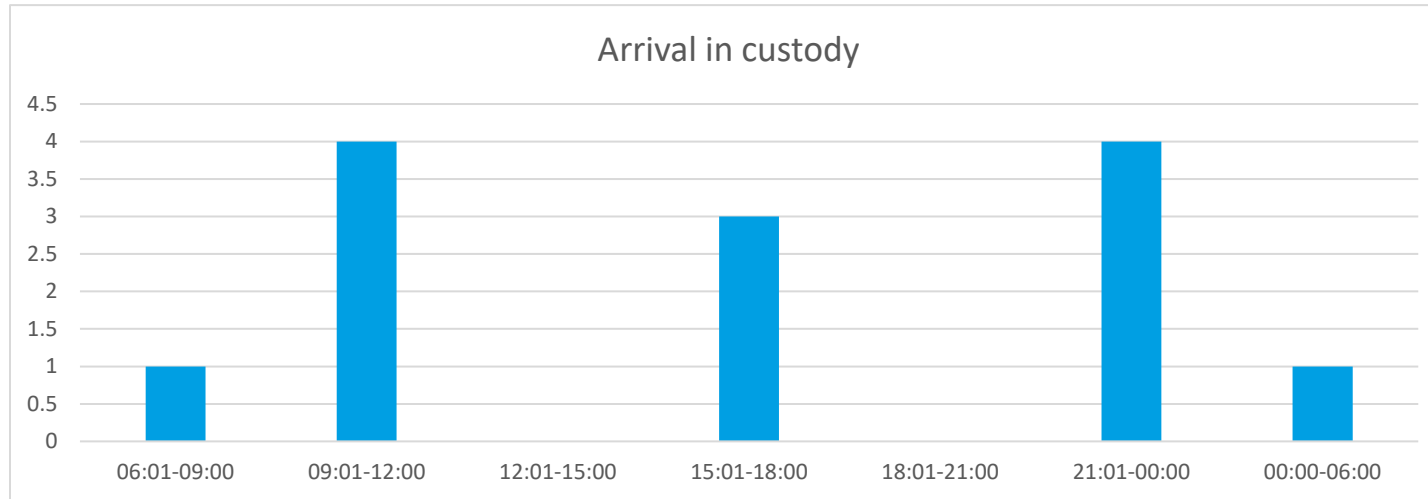
Age

- The highest proportion of juvenile detainees recorded in custody were 15 years of age with 68%.
- The smallest proportion of juveniles in custody with 5% were 16 years of age, with the other ages from 13,14 and 17 years old with the value of 9%.

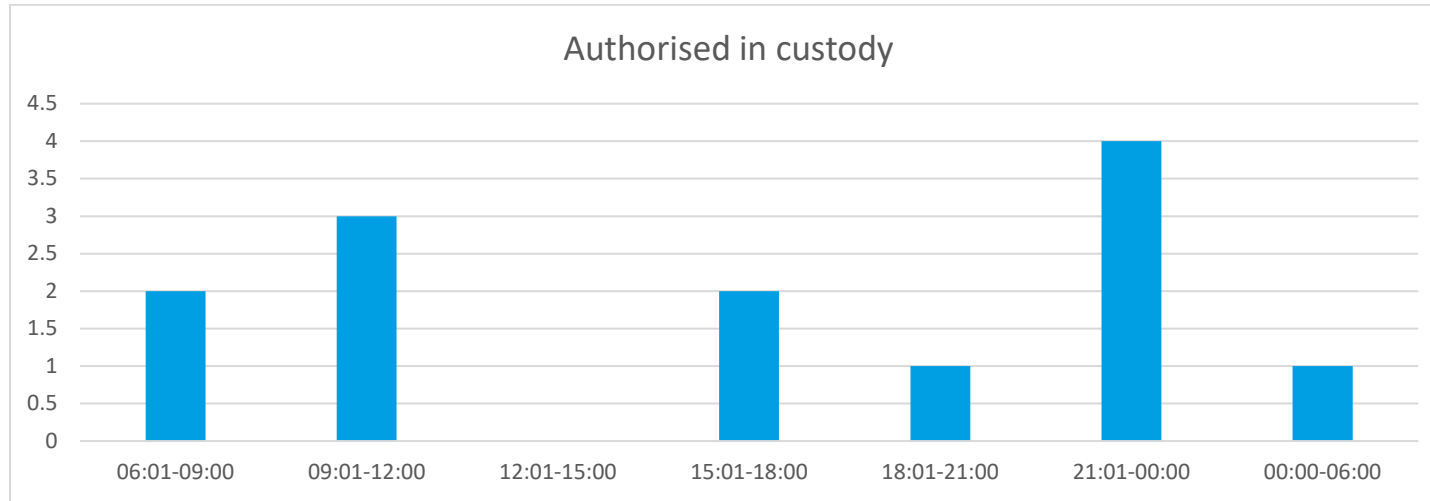
Ethnicity

- All juvenile detainees that were in custody were recorded as White British or White North European.
- There were no black or other ethnic minorities recorded from this dip sample.

Times Arrived in Custody



Times authorised into Custody



Time lapsed from arrival to detention authorised

- The average time lapsed from the point a juvenile detainee arrived at custody and was authorised for detention was 29 minutes.
- The highest waiting time was 2 hours and 19 minutes.
- The fastest time for a juvenile to have their detention authorised is 9 minutes.
- The Panel were unable to locate or specified that there was no rationale provided for any delay in authorising any of the juvenile detainees.

Total Time in Detention

- The average time a juvenile was held in custody was 12 hours and 8 minutes.
- The longest time a juvenile was held in custody was 20 hours and 22 minutes.
- In contrast, the shortest time a juvenile was held in custody was 2 hours and 10 minutes.

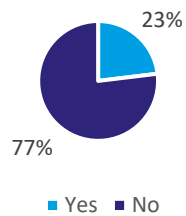
Religious Requirements

- No Panel member could ascertain whether religious items were offered or requested in any of the custody records reviewed.

Special Dietary Requirements

- 84% of juvenile detainees were asked if they had any special dietary requirements in contrast to the 8% who had not appeared to have been asked or that had been asked but no detail could be found in the record.

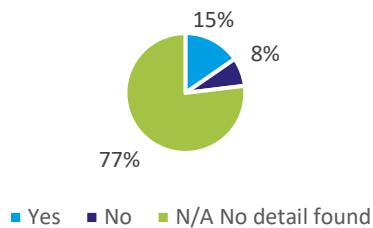
Was the Detainee Instructed about the Cell Call Bell



Cell Call Bell

- 77% of the Panel could not ascertain on the record that juvenile detainees were instructed regarding the call bell located within their custody cell.
- 23% recorded that detainees had been instructed.

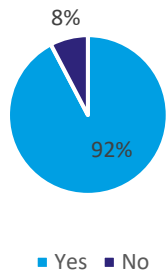
Was the Detainee informed about toilet pixelation



Toilet pixelation

- 77% of the Panel could not find any information that specified that toilet pixelation had been advised to the juvenile DP during their detention.
- 15% recorded that they had and 8% recorded that they had not.

Food Refreshments Offered



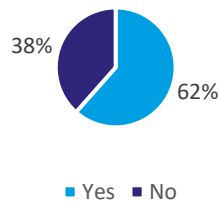
Food Refreshments Offered

- 92% of custody records reviewed had recorded that juvenile detainees were offered food and refreshments.
- Whilst juveniles were offered food and refreshments, the Panel also noted that there were occasions when it was not recorded whether custody had enquired whether the detainee had any allergies or that it had been reported at various times that the DP had been offered refreshments but there were no specific times listed in the custody record.

Female Officer Assigned for a Female Juvenile DP

- Of the three female juvenile detainees recorded, they were all assigned a female officer.
- With regards to menstrual products, only two were recorded as being offered whereas there was no record specified for one of the case records.

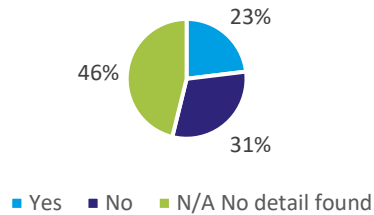
Hygiene Requests (including Showers & handwash)



Hygiene Requests

- 62% of detainees were recorded as being offered showers and handwashing facilities.
- 38% had not been offered this.

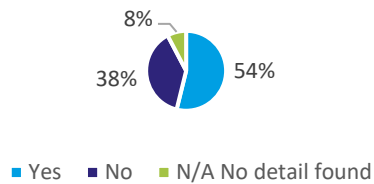
Is there evidence of a CEWS score being undertaken?



Custody Early Warning Score (CEWS)

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

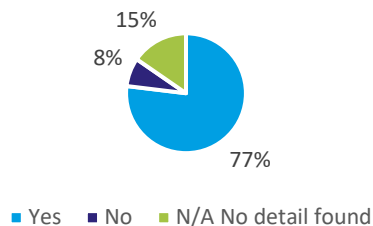
Was there a delay in receiving R+E (e.g. with AA/interpreter present) of more than 1 hour?



Rights Entitlement

- All juvenile detainees were given their rights either at the booking in stage or at some stage during their detention.
- This graph illustrates that 54% of juvenile detainees experienced delays in being offered their Rights and Entitlement booklet; however, this booklet is optional which reflects that 38% declined the option of having the booklet whilst detained.

Did the DP see or speak to a Solicitor?



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

- The average time for a juvenile detainee took to request a solicitor was 1 hour and 27 minutes.
- In 5 of the cases, a juvenile made the request for a solicitor within 10 minutes.
- The longest period for a DP to request a solicitor was 13 hours.
- 77% of juvenile detainees saw or spoke with a solicitor during their detention. 15% could not find the detail recorded within the custody record.

The length of time taken for police to contact a solicitor

- The average time taken was 1 hour and 48 minutes for police to contact an on-duty solicitor.
- The longest period of time was 3 hours and 10 minutes.
- The shortest was immediately after being requested.
- It must be noted that in 4 of the cases, the Panel were unable to find the time taken either because the information on the form made it difficult to ascertain, or due to this record not being recorded on the custody record.

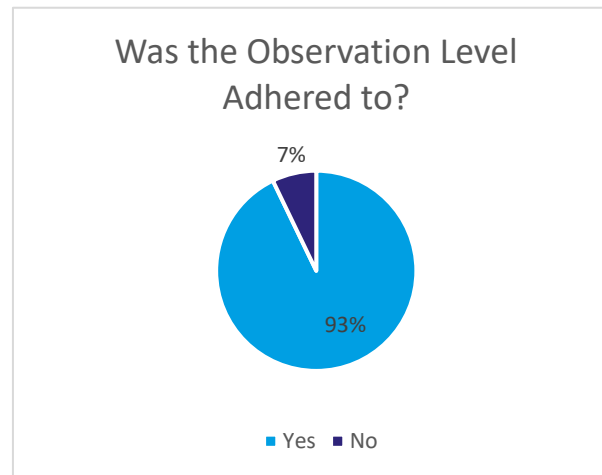
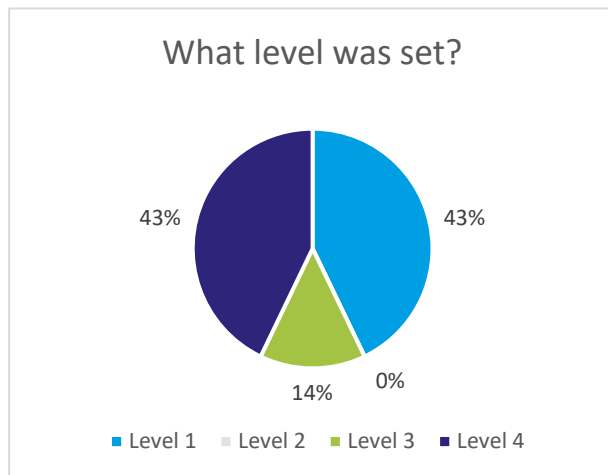
The length of time taken for solicitor to arrive from the point of being contacted

- The average time for solicitor to arrive was 8 hours and 14 minutes.
- There were two occasions where a solicitor arrived after 15 hours of the juvenile being detained.
- The shortest time noted was 1 hour and 18 minutes.
- The Panel had noted on the following occasions:
 1. A duty solicitor was not available and the DP was provided with another solicitor already on site seeing a different DP.
 2. No record of certain solicitors arriving at the custody suite or noting that a meeting had taken place.
- In the circumstances that there was a delay in a solicitor visiting, 33% had provided a rationale; whereas 67% had provided no rationale observable to the Panel on the custody record.



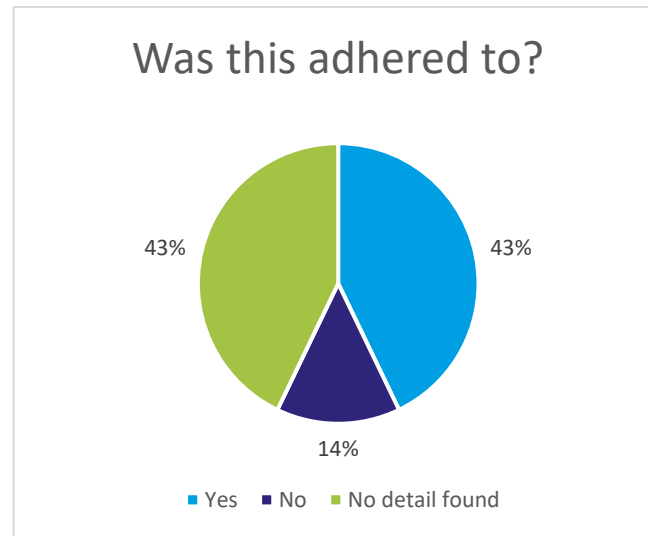
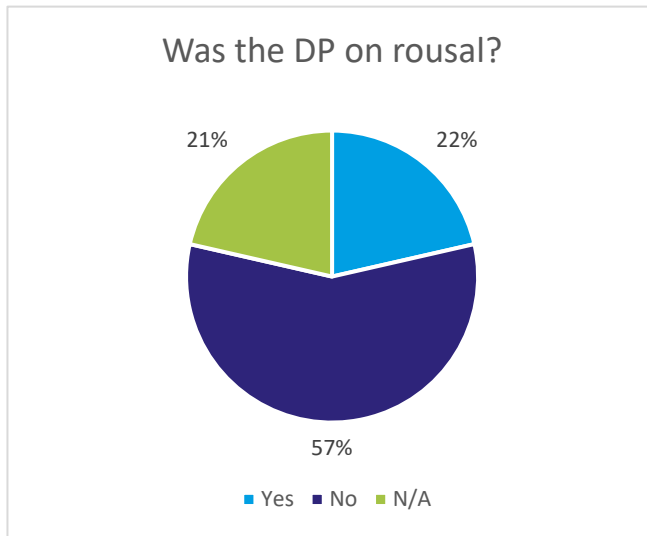
Observation level

- The Panel recorded 100% confirmation that all juvenile DP's risks has been taken into account with the rationale recorded.
- The risk level is judged on 4 levels.



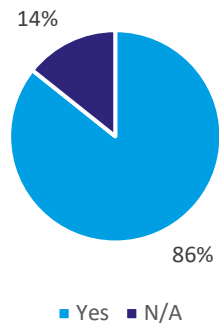
- Level 1 General (at least once every hour)
- Level 2 Intermittent (every 30 minutes)
- Level 3 Constant (constant observation CCTV and accessible at all times)
- Level 4 Close Proximity (physically supervised in close proximity).
- Level 4 was recorded as the most prevalent risk grading with 43%.

- 89% of observation levels were deemed to have been adhered to in comparison to 11% that had not.



- Comments raised by the Panel on the observation level and if it was adhered to:
 - a) *The Observational level was changed from Level 4 to Level 1 once Appropriate Adult had arrived.*
 - b) *The custody staff conducted good observations for all levels.*

Was the DP given access to/offered/referred to any support services?



Support Services

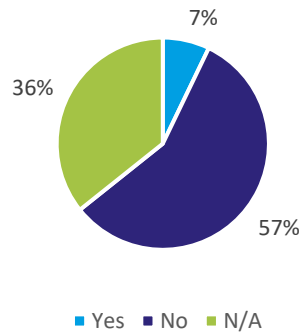
- 85% of juvenile DPs were offered support services.
- The Panel noted the following services being offered were social services, Child and Adolescent Mental Health Services (CAMHS) and Youth Offending Team (YOT).

Healthcare Professional (HCP) and Anti-Rip Suits

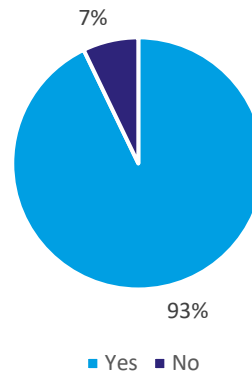
Reason for Rating	Follow Up Action
Drop down in use, full rationale for use of suit, which is both justifiable and proportionate to risk posed.	No further action required at this point.
Suit removed as soon as practicable.	
Clear de-escalation, distraction items etc. used to mitigate risk of detainee DSH.	
Little or unclear justification for the use of the suit.	Advice/further training given to custody staff.
Insufficient 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	

- The below pie charts illustrate the use of anti-rip suits to juvenile DPs and option for a healthcare professional (HCP):

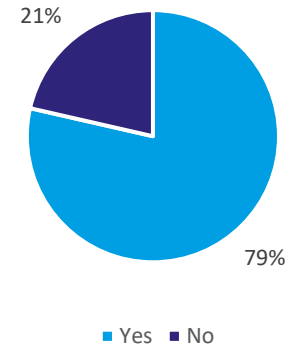
Was there a delay in healthcare professionals attending and DP receiving a health assessment?



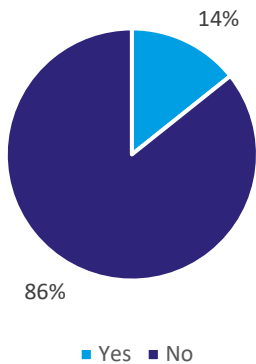
Did the detainee engage with the risk questions?



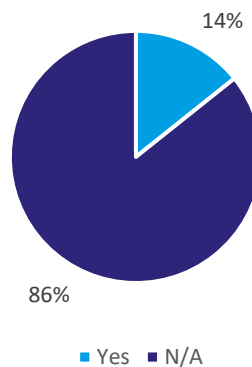
Did the DP see a healthcare professional



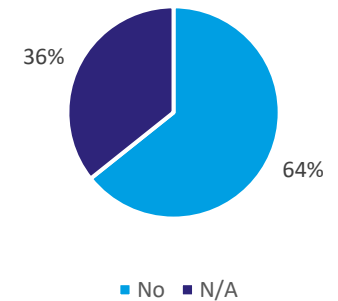
Was the detainee given a safety suit/anti rip-suit to wear?



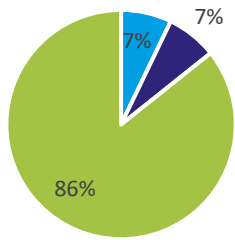
Where a suit was provided has a rationale been provided?



Where a suit was provided, has the anti-rip suit custody system drop down been used?

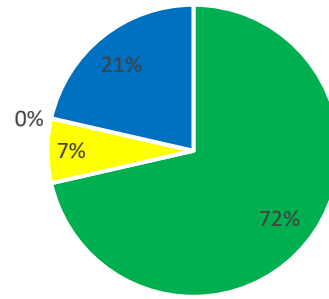


Does the record contain evidence of the anti-rip suit being discussed in staff handovers?



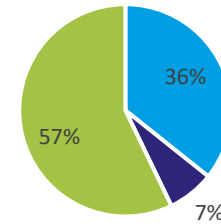
■ Yes ■ No ■ N/A

RAG Grading



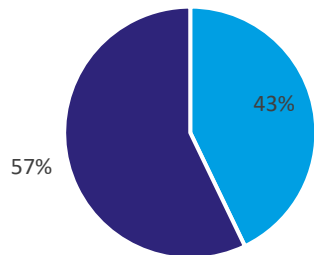
■ Green ■ Amber ■ Red ■ N/A

If clothing was removed, were there continuing risk assessments?



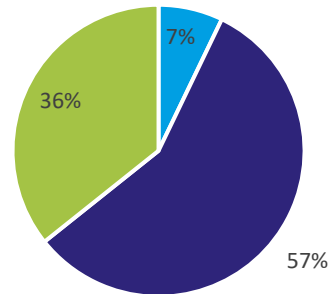
■ Yes ■ No ■ N/A

Was the detainee assessed as at risk of self-harm?



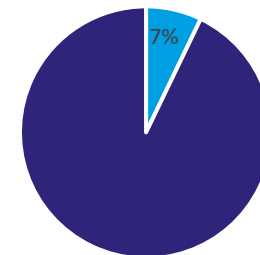
■ Yes ■ No

Was clothing removed by force?



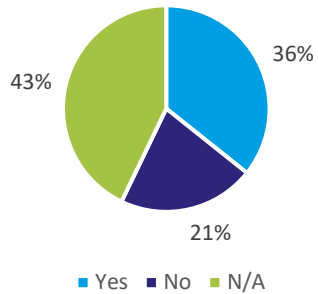
■ Yes ■ No ■ N/A

Was there a good rationale for strip search?



■ Yes ■ N/A

Does the record contain evidence of de-escalation, distraction items or other methods of reducing the detainees risk level?



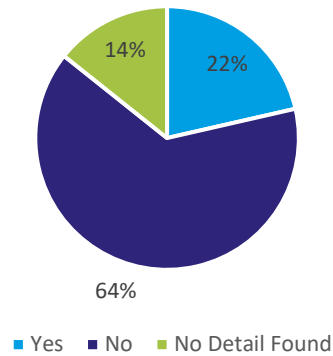
Overall, the Panel noted that:

- 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) Under very difficult circumstances, custody staff have responded well.
- d) From the isolated incident involving a DP's clothes being removed, appropriate rationale was provided which included their behaviour whilst being escorted to custody which was noted as being violent, very intoxicated and threatening to make a ligature around their neck.

- The Panel noted that in majority of cases, anti-rip suites were not used. There were three occasions where a grey tracksuit was used due to DP having suicidal thoughts or the DP's clothes were seized for evidential purposes.

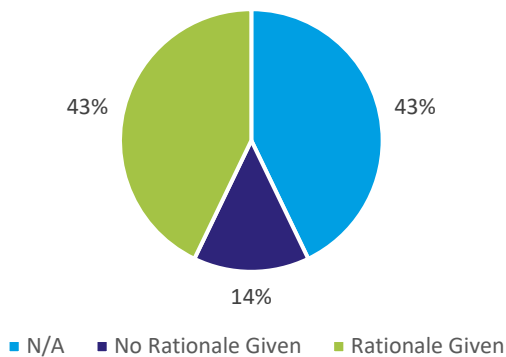
- The Panel had the following comments regarding custody's approach to Mental Health:
 - a) Good sharing of information between organisation including social services, the general practitioner.
 - b) Good risk assessments which included DP's vulnerabilities involving self-harm or mental health.
 - c) In many of the cases, the juvenile DPs were treated fairly and compassionately.

If Nominated Person/AA not contacted was a reason recorded?



travelling from long distances.

Was there any rationale available for a delay in AA's arrival?

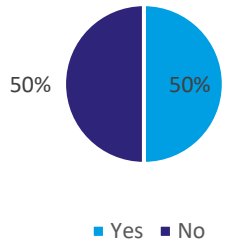


Appropriate Adults (AA)

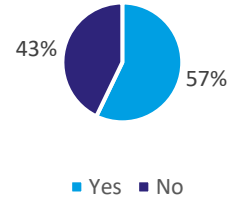
- The Panel noted that in all cases, the Force had identified that an Appropriate Adult was required. The Panel also advised that all AA or nominated persons were contacted
- 22% of the custody records reviewed had provided their rationale.
- The average time for the first time police made contact with AA was 3 hours and 34 minutes.
- The longest period of time for a detention officer to contact an AA was 13 hours with the second longest being 10 hours and 10 minutes.
- On five occasions, the contact was made straight after the request was made.
- Certain members of the Panel could not find this detail noted in the custody record, whereas another member noted that there were difficulties with the AA travelling from long distances.
- The average time for a DP to have first contact with an AA was 4hrs and 31 minutes.
- The Panel noted 33% of cases reviewed had provided a rationale for a delay with AA arrival, in comparison to 17% which had not and 50% not being applicable.
- The Panel raised the following comments regarding AA provision:
 - a) *There were a number of occasions when the parent of the juvenile refused or were unable to be the AA. This required Custody staff to make a number of attempts to other services such as Social Services for support.*
 - b) *There have been a number of cases identifying difficulty in being able to contact the Local Authority/Social Services.*
 - c) *A number of cases were identified a lack of available AAs.*

Children in Custody

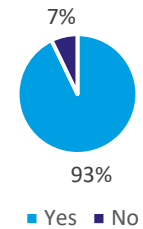
Was the child charged?



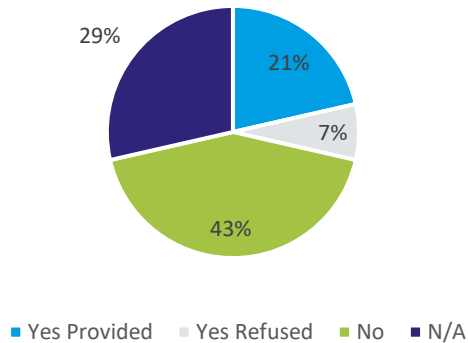
Was the young person detained overnight?



Was the Children in Custody checklist used?

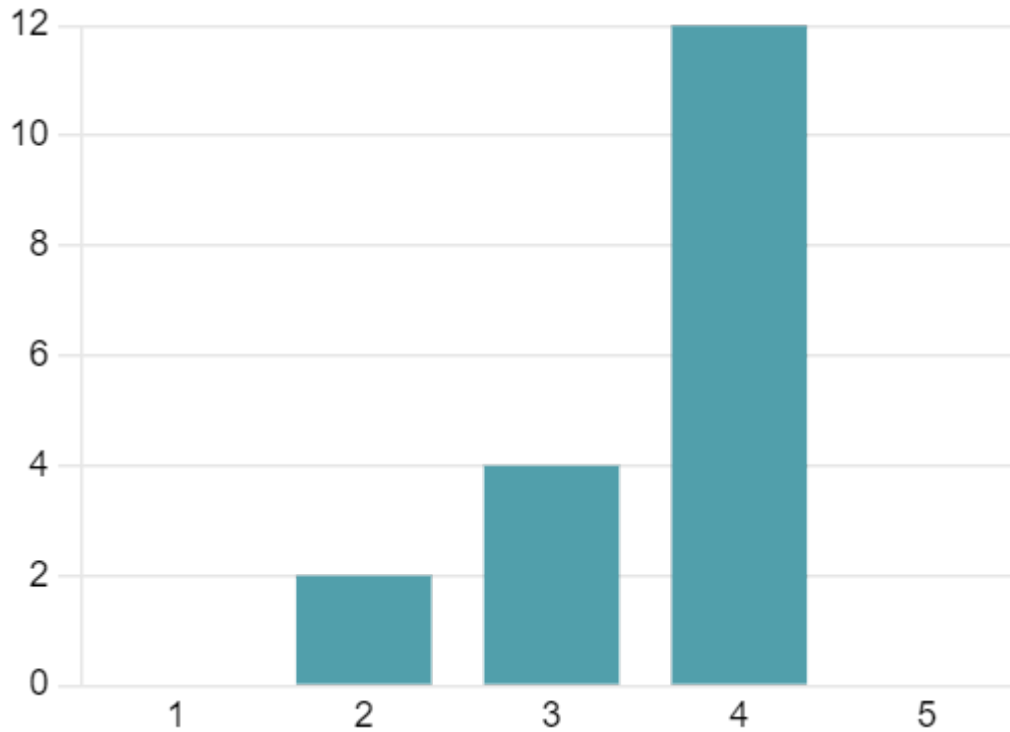


Was an alternative care setting sought?



- The Panel raised the following comments in relation to any rationale provided for children being kept in custody overnight:
 - Majority of arrests occurred in the early hours of the morning which meant that in a number of occasions, custody were awaiting for appropriate accommodation on release.*
 - There was one occasion where a DP was intoxicated and therefore could not be interviewed.*
 - There were two instances whereby there was a difficulty in obtaining a Care Home as the DPs were located outside of the Dyfed-Powys area.*
 - There was an instance where the parents had declined to have the DP return to the home address.*

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 out of the 18 custody records reviewed was 3.56.