



Mae'r ddogfen hon ar gael yn Gymraeg yn ogystal â Saesneg.

This document is available in Welsh as well as English.



Comisiynydd Heddlu a Thro seddu  
Dyfed-Powys  
Police and Crime Commissioner



Heddlu Police  
**DYFED  
POWYS**

October 22<sup>nd</sup> 2025

Police and Crime Commissioner for Dyfed-Powys  
Authored by: Tom Walters

## Custody Independent Scrutiny Panel: Children in Custody

---

# Contents

<b>Introduction.....</b>	<b>2</b>
<b>Summary of Findings.....</b>	<b>4</b>
<b>Panel Observations.....</b>	<b>7</b>
<b>Annex- Custody Record Review Findings .....</b>	<b>23</b>
<b>Demographics .....</b>	<b>23</b>
<b>Custody Suites .....</b>	<b>24</b>
<b>Time Arrived in Custody .....</b>	<b>24</b>
<b>Provisions in Custody .....</b>	<b>26</b>
<b>Female Detainees .....</b>	<b>28</b>
<b>Hygiene .....</b>	<b>29</b>
<b>Rights and Entitlements .....</b>	<b>31</b>
<b>Observation Level.....</b>	<b>34</b>
<b>Support Services.....</b>	<b>36</b>
<b>Healthcare Professional (HCP) .....</b>	<b>37</b>
<b>Special Risk Clothing (SRC)/Anti-Rip Suites.....</b>	<b>38</b>
<b>Use of Force .....</b>	<b>39</b>
<b>Strip Search.....</b>	<b>40</b>
<b>Mental Health (MH), Appropriate Adults (AA) &amp; other Vulnerabilities .....</b>	<b>41</b>
<b>Children in Custody.....</b>	<b>42</b>
<b>Red Amber Green (RAG).....</b>	<b>44</b>

# Introduction

The origins, purpose and the rationale for the Custody Independent Scrutiny Panel (CISP) can be found on our webpage under the Terms of Reference (ToR) via this link: [Dyfed-Powys Police & Crime Commissioner](#).

In October 2025, the CISP focussed on Children in Custody (CIC). In preparation of this scrutiny activity, the Panel were reminded of the *Summary of Findings* from last year's report which can be viewed [here](#).

As of June 2025, Dyfed-Powys Police (DPP) have changed the process in relation to processing CIC. The process now includes:

- An operational frontline sergeant (not based in custody) to review the necessity of the arrest of the child with the arresting officer with the purpose for the Sgt to explore other suitable options in place of the child being detained in custody.

- Once confirmed that child is to be brought to custody, there is the introduction of the 12-hour PACE (Police and Criminal Evidence act) clock specifically for CIC, which includes:

1) **First review** between **hours one and two** to ensure the child has been prioritised in custody.

2) The **second review (six-hour PACE** review) will remain as normal.

3) **The third review** between **hours 11 and 12** to ensure the investigation is being conducted expeditiously. This will include a discussion with the investigating officer, ensuring that Appropriate Adults have been allocated, and assess the progress of the investigation to justify their detainment.

4) If it is determined following the third review that the continued detention of the child is necessary and proportionate, an additional PACE review is to be carried out at hour 15 through the normal "Review" log entry process.

This is in comparison to how an adult or a child (nationally outside of DPP) is arrested and taken to a police station, where under PACE, they can be held for 24 hours without being charged. This detention includes:

1. First review within 6 hours of the adult's detention.
2. Next review is every 9 hours.

---

3. After each review, the inspector must be satisfied that the detention is still necessary, the legal conditions for detention are still met and the person's welfare are being adhered to.

The CISPs were also reminded of the purpose of the Children's Checklist. This is a 23-question document designed to understand why the child has been arrested and establishes any preventative measures upon release to ensure the child does not return to custody. Below are two main details found within the checklist that the CISPs will be assessing:

- **Voice of the child**- this is a tool that captures the views of CIC.
- **Reachable Moments**- is an opportunity where the child/young person reaches out for support who may have previously refused to engage.

Whilst for the purposes of this report the CISPs are assessing the Force's compliance of Reachable Moments within the Children's Checklist, the OPCC in collaboration with the Force, are in the process of commissioning an external Youth Justice service to support custody with ensuring Reachable Moments are being captured in custody more efficiently, as it is felt that this sits outside of custody's remit and that a Youth Justice worker would specialise in this important area of engagement. It is hoped that this service will commence by the end of this year.

The Panel were provided with these additional questions to consider during their scrutiny activity which included:

- Has there been an Inspector's review within 1-2 hours of the child detained?
- Has the arrest been reviewed by the Sergeant (not Custody Sergeant)?
- Has the 6-hour PACE review been completed?
- Has the third Inspector review taken place (12hour PACE clock for children)?

To view the set of questions the Panel were asked to consider you can select [here](#) or view via the QR code:



---

# **Summary of Findings**

Below is a summary of some of the findings by the Panel:

## **Positives:**

### **Total Time in Detention**

- The average time a detainee was held in custody was 4 hours and 41 minutes, which in comparison to last year's report of 18 hours and 13 minutes, is a dramatic improvement.

### **Inspector Reviews**

- Given the changes to CIC procedures, it is positive to see that Inspector reviews have been adhered to in this dip sample.

### **Rights & Entitlement**

- All rights were provided to CIC either at booking in or at a later stage in the CIC detention. This is consistent with last year's reports findings, which is pleasing to see.

### **Use of Force**

- Only one record of the 10 had displayed UoF in custody. In relation to the single record, the CISPM member determined that this was proportionate due to risks posed by the CIC of self-harm and UoF was used to ensure their safety. There were no injuries to the CIC nor the staff involved.

### **Strip Search**

- There was only one CIC that had received a Strip Search and the CISPM member reviewing this record specified that the rationale was provided and was proportionate for the child's safety.

### **Arrests Necessary and Proportionate**

- The CISPM found no evidence that any CIC was detained unnecessarily.

---

## **Areas for improvement:**

### **Appropriate Adult**

- The average time first contact was made between the CIC and the AA was 4 hours and 16 minutes. This is in comparison to last year's report which specified the average time was 2 hours and 2 minutes. In three instances, the CISPR found no rationale provided for the delay.
- In one instance, custody staff were hesitant to contact the Emergency Duty Team (EDT) to support a CIC during their early stages of their detention.

### **Children's Checklist**

- 3 out of 10 custody records reviewed by the CISPR did not contain a Children's Checklist.
- Of the 7 records which had the Children's Checklist, 4 did not contain the Voice of the Child, meaning only three Children's Checklists were completed appropriately for CIC.
- In one record that did complete the Children's Checklist, it has been determined that the VOC (Voice of the Child) lacked sufficient detail for a complex individual with a number of self-harm and mental health needs.

### **Prioritising CIC**

- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 2 hours and 14 minutes. In comparison to last year's report this was 14 minutes which is an increase of 2 hours.

### **Missing Entries within Custody Record**

- A number of custody records show missing entries including legal representation arriving, booking in and authorising detainees.

### **External Agencies**

- Difficulties obtaining an AA or securing accommodation for CIC has been attributed to limited resources/availability of Social Services out of office hours.

### **Female Officer Allocation**

- In one custody record, the Custody Sergeant had justification to assign themselves as the allocated female officer to support a female CIC; however, the allocation did not change following handover.

---

- There is also another record that showed that a female CIC was not allocated a female officer, due to the short period that they were detained.
- The Force have acknowledged that this is an area that needs to improve.

### **Delays in processing CIC for Detention**

- There was one instance whereby a CIC was delayed their 6-hour PACE review by 1 hour and 20 minutes due to other operational matters. The Force have advised that they do not have dedicated PACE inspectors and are required to support other operational factors in their region; thereby affecting custodies statutory responsibilities for detainees.
- A recording error by a CISPC member may have contributed in the average detention time higher than recorded in this report.

# Panel Observations

Force comments were produced by an Inspector of Custody Services for Dyfed-Powys Police.

Theme	Observation	Force Response
<b>Children's Checklist</b>	<p>Of the 10 records viewed, 3 did not have the Children's Checklist. Of the 7 records which had the Children's Checklist attached to the records, 4 did not contain the Voice of the Child.</p> <p>Can you clarify why there are custody records missing Children's Checklist?</p> <p>Will the completion of Children's Checklists be a particular focus for the Force moving forward?</p>	<p><i>Child checklists being missed is primarily due to human error.</i></p> <p><i>The completion of child checklists has been a priority for DPP Custody for a sustained period and will continue to be a focus of scrutiny moving forward. Whilst focus over previous months has been to improve compliance regarding completion of the checklist, greater scrutiny will now take place regarding the quality of the content contained within them.</i></p> <p><i>Custody Services completes a 100% audit of children in custody each month, and part of that audit focuses on the completion of the child in custody checklist.</i></p> <p><i>Completion of the checklist also now forms part of Daily Management Meetings on each Basic Command Unit (BCU).</i></p> <p><i>As a brief insight, over the past two months DPP has seen 55 children in custody with only 5 checklists missed. This means 90% compliance. However, Custody Services expectation is compliance should be 100% every month.</i></p>
<b>Inspector Review</b>	<p>There was one custody record where the 2-hour review was logged 2 hours afterwards by the inspector and the 12-</p>	<p><i>I have reviewed the custody record and the first line of the "2-hour review" entry states that "This review was conducted and typed up but not placed on the log due to ongoing incidents in B &amp; C div". This first line highlights the reason for the delay being that the inspector had</i></p>

	<p>hour review, was provided by the inspector in the 15 hour review.</p> <p>Having reviewed the record was there justification for the delay or is there any learning identified for this custody record?</p>	<p><i>conducted the review, spoken with custody officers, but had then been committed with other operational commitments in two other divisions, namely Pembrokeshire and Ceredigion, as part of bronze inspector duties.</i></p> <p><i>In relation to the 12-hour review, this was not completed as part of the 15hr PACE review, it was missed. It must be remembered that these additional reviews are part of a pilot process that is under review by Custody Services but is not governed by PACE. These new processes remain under review by Custody Services and Chief Officers as the pilot continues.</i></p> <p><i>I suspect that it may have been difficult for panel members to be able to accurately identify the difference between PACE reviews and the additional pilot reviews after receiving some brief guidance.</i></p>
<b>Specific Case (highlighted in Amber)</b>	<p>This record did not appear to have a 2-hour Inspector review and there appeared to be no explanation of the delay between arrival in custody and the authorisation of detention (3 hours 31 mins).</p> <p>It was also noted in the same custody record that the longest period for custody to contact the solicitor was 10 hours and 13 minutes after authorised detention. Can this be validated; and if so, was there a justification for the delay for authorising the detention and delay for providing legal representation?</p>	<p><i>The additional 2-hour inspector review was completed and is recorded on the detention log.</i></p> <p><i>The delay between arrival and detention authorised was 3hrs 18mins. The "booking in" section was signed by the following custody officer after receiving a handover at 0023hrs. This is also accompanied by a detention log entry which highlights that the box was not signed in error by the previous custody officer. Feedback has already been provided to the custody officer who forgot to sign when authorising detention.</i></p> <p><i>In relation to the delay in contacting a solicitor, the DP initially declined legal advice as per log entry at 2208hrs following his arrival in custody. These rights would need to be revisited following arrival of AA, but at that time the wishes of the DP had to be respected. Custody staff</i></p>

		<p><i>then made attempts to arrange the attendance of an AA via Emergency Duty Team (EDT-on-call social worker) as it was out of hours. EDT could not attend custody due to other ongoing matters and was the only on-call social worker for the area. This meant that the attendance of an AA was delayed until office hours the following morning. Once AA attended the following morning, rights were revisited and solicitor request completed at that time. It could not have been completed any earlier under the circumstances.</i></p>
<b>Appropriate Adults (AA)</b>	<p>The average time that first contact was made between the CIC and the AA was 4 hours and 16 minutes. The average time was impacted by two records that specified a delay of 11 hours and 17 hours.</p> <p>Factoring these two records, the average time would have been 1 hour and 29 minutes. Given that last year's report saw an average of 2 hours and 2 minutes, could the delays of those two records be improved or is this an area the Force needs to prioritise for CIC moving forward?</p> <p>There were three instances where the CISP could not ascertain the rationale provided for the delay. Can this be confirmed and advise if there is any learning identified from this observation?</p>	<p><i>In relation to the first record – efforts could have been made to reduce this delay. The custody record states that social services would be contacted in the morning to attend as AA, but efforts could have been made to request EDT attend outside of office hours as the DP arrived following midnight. The DP's behaviour was unpredictable, evidenced in the care plan, whereby she was attempting to cause harm in the cell. However, efforts should still have been made to contact AA earlier. This is not a regular occurrence with regard to securing AA attendance for children and feedback has been provided to the custody involved during the early stages of this detention.</i></p> <p><i>In relation to the second record – custody staff made every effort to secure the early attendance of an AA. Again, due to the arrival being outside of office hours, EDT (on-call social worker) had to be contacted to attend custody as AA. Unfortunately, on-call EDT was unable to attend due to other commitments. Due to this, custody staff then explored an overnight placement address for the DP which would have allowed the DP to be bailed from custody. However, EDT had no suitable placements available for a child of the DP's age. This meant that AA did not attend until the following</i></p>

		<p><i>morning. This was not within the control of the custody staff.</i></p> <p><i>In relation to the third record – Care plan, rights and entitlements sections, and several detention logs on custody record highlight that the DP did not want his father informed of his arrest or for his father to act as his AA. The DP did not have contact with his father and no longer resided with him. DP stated he previously used his grandmother, but she had moved to Italy. No other relatives could be identified and so EDT (Social Services) were requested to assist but stated that they were unable to attend until 1930hrs, which explains the delay in AA attending custody and meeting with DP.</i></p> <p><i>All these cases highlight the ongoing issues presented to custody when trying to obtain an AA from local authority outside of office hours. In most cases, there is often only 1 on-call social worker on duty covering the area and so are unable to attend custody physically due to other ongoing commitments as part of their role. This then causes delays in AA attendance at custody until the following morning when office hours commence and more staff become available from Social Services or Youth Offending Teams. This is down to the capacity of the local authority, which is completely out of the control of DPP custody staff. Bail is always a consideration, but several variables must be taken into account such as the severity of the offence, safeguarding of both the detainee and any victims/witnesses, securing suitable alternative accommodation, etc.</i></p>
<b>Observation Level (Inspector Review)</b>	A CISP member specified the following: "The custody sgt has assessed the level as 4 observations. However on inspector review it appears that the assumption has	<p><i>Custody record has been reviewed and at the time of the inspector reviews the DP was on level 1 observations not level 4.</i></p>

<p><i>been made that DP (Detained Person) is on Level 1. The custody staff are clear that its Level 1 and undertaking these checks with AA also present. It is concerning that Inspector has not looked at the whole custody log to see the level 4 or have only looked at the medical level 1."</i></p> <p>In the same custody record, the CISP member has also specified that it does not appear that the VOC has been recorded within the Childrens Checklist and queried whether the disclosure of self-harm was taken seriously when it was reported on two occasions by the CIC.</p> <p>Can you clarify the inspector's review and verify if there is any learning to be taken from this observation?</p>	<p><i>Care plan completed at 10:16hrs shows the DP on level 1 30-minute observations</i></p> <p><i>First additional inspector review completed at 10:34hrs.</i></p> <p><i>Care plan completed at 14:59hrs shows the DP on level 1 30-minute observations.</i></p> <p><i>First PACE review at 6hrs completed at 15:36hrs.</i></p> <p><i>DP was then changed to level 4 observations at 15:54hrs, after the inspector reviews had been completed.</i></p> <p><i>The above information, along with the timings, may have been difficult for the panel member to extract from the PDF version of the custody record that was provided.</i></p> <p><i>The rationale for the change in observation levels is captured in the care plan whereby the DP was initially placed on L1 observations, but after being placed in the cell, the DP's behaviour escalated, and the DP stated that this was because DPP cells did not have glass fronted doors like the ones in Met Police. DP stated that he will likely harm himself in the cell because of this. Therefore, DP was placed on level 4 observations.</i></p> <p><i>This change in observation levels highlights that the disclosure of self-harm has been taken seriously by the custody staff, as well as the DP being booked to be seen by the HCP on two occasions. The DP was first seen by HCP on arrival at custody at 09:40hrs, as per force policy, and then prior to his release for a "fitness to release" examination due to the comments made during detention regarding self-harm. Custody staff also ensured that Social Services and Met Police were aware of this information prior to release.</i></p>
---	---

		<p><i>VOC was captured on the child checklist as follows:</i></p> <p><i>"DP presents well at the desk his appearance is normal for a person of his age.</i></p> <p><i>DP speaks well and is clearly able to understand the questions asked of him.</i></p> <p><i>DP behaving in a normal manner.</i></p> <p><i>DP's mother aware of his arrest and DP Has spoken to her on the phone. She is in London so unable to attend.</i></p> <p><i>YJT will act as AA.</i></p> <p><i>DP not happy that he is in Wales and says that he is not safe here."</i></p> <p><i>I am unsure whether the panel member has mistaken "Reachable Moments" not being completed as opposed to VOC. Whilst Reachable Moments was not completed, this will soon be covered by the Reachable Moments Project which will go live in DPP within the coming weeks and will involve suitably trained professionals attending custody to support all child detainees.</i></p>
<b>Specific Case (highlighted in Red)</b>	<p>CIC was detained for 15 hours and 12 minutes with the disposal method being NFA, with the arrest necessity specified as '<i>To prevent physical harm to themselves or other</i>' only.</p> <p>A female officer was not assigned to the female CIC; although the CISPA member did note that the Custody Sgt was female. Can you verify whether the Custody Sgt assigned themselves as the assigned officer for the CIC; and if so, do you deem this to be appropriate? Additionally, due to the specified vulnerabilities regarding this female CIC, particularly due to their young</p>	<p><i>Custody record reviewed and circumstances of arrest document that DP had been arrested for common assault following numerous calls made from the DP's home address regarding her aggressive behaviour towards her mother and younger siblings at the address. This involved the DP throwing a wooden drawer at her mother. A review of the investigation occurrence highlights that there were no alternative addresses that could be identified for the DP, due to the DP's aggressive behaviour at scene, and it was not appropriate for her to remain at the home address as the DP posed a risk to her mother and younger siblings. The DP had also self-harmed prior to arrest which required her to be taken to A&amp;E before arriving at custody. Therefore, both the DP's</i></p>

	<p>age and mental health, and given the disposal method, do you consider their detention to be justified?</p>	<p>arrest "to prevent physical harm to themselves or other", as well as her detention at custody, was justified.</p> <p><i>This custody record was reviewed as part of the children in custody process changes and not highlighted by Custody Services as a "missed opportunity" to prevent a child coming into custody.</i></p> <p><i>All vulnerabilities were captured during the risk assessment and care plans, as well as conversation with the DP's mother to ascertain all confirmed mental health diagnoses. Vulnerabilities were assessed by HCP, relevant referrals made to support services, and safeguarding completed.</i></p> <p><i>The panel member has correctly recorded that the assigned female member of staff was the custody sergeant on duty. The care plan states that the custody sergeant allocated herself as the dedicated female for the DP as there were no other female officers on duty in Pembrokeshire. Whilst allocating the custody officer as the female member of staff should be a last resort, it appears that it was on this occasion, and it would not have been proportionate to ask another female officer from another division/BCU to travel a significant distance to custody for this purpose.</i></p> <p><i>However, it does not appear that the allocated female officer was changed following handover and feedback has been provided to the incoming custody officer as part of the quality assurance and feedback process.</i></p> <p><i>The outcome being NFA should not be used solely as a benchmark to determine whether arrest/detention is necessary or justified. Whilst it can be used as an</i></p>
--	---	---

		<p>indicator, it should also be assessed along with the context of the offence under investigation, the circumstances of the child, what other options were explored, and the reasons for the NFA decision being made. On this occasion, the victim who was the DP's mother, was not supportive of a complaint and so there was insufficient evidence to proceed any further.</p>
<p><b>Specific Case (highlighted in Red)</b></p>	<p>CIC was detained for 16 hours and 35 minutes, with the necessity of the arrest being 'To prevent physical harm to themselves or other'. They were released with NFA and the CIS member noted that the standard of the Children's Checklist was not of a good standard, highlighting: <i>"This juvenile Appears to have slipped through several safety nets and a complex case as to safeguarding self harming. Care by custody staff was good but processes and other services let her down. This could not have been a positive outcome for this young person and wanting to self harm and not having support of AA early. She self harmed in custody and needed some intervention on leaving. Where these issues could be highlighted they were missed in Inspection review and Health assessment. She is vulnerable and ultimately NFA so could she have been dealt with differently from the start. The Childrens checklist is poorly completed."</i></p> <p>With reference to the Use of Force (UoF), they specified that the Inspector's 12-hour review had dismissed that UoF had been used despite the CIC having handcuffs</p>	<p><i>Custody record reviewed and the panel member rightly highlights this as a complex case, with numerous safeguarding concerns, and a difficult detainee for the custody staff to manage safely.</i></p> <p><i>Firstly, focusing on the circumstances of the arrest, the DP was reported as a missing person with concerns of self-harm/suicidal thoughts. The DP was located and returned home into the care of her mother but then assaulted her mother in the presence of officers. No other alternative addresses could be identified by either the DP's mother or officers at scene, and it was not appropriate to allow the DP to remain at the home address as this would pose a safeguarding risk to her mother, as well as the DP who had already been reported as missing. On review of the occurrence, the attending officers did not deem the DP's behaviour to be meet the criteria for police powers under S136 Mental Health Act and once returned to the home address these powers would not have been available to officers as these powers do not apply to private dwellings. Therefore, arrest and detention were justified. This was not identified as a "missed opportunity" during Custody Services reviews of all child detentions.</i></p> <p><i>I am unable to comment on "other services let her down" as this is not within the control of custody staff. However, from reviewing this custody record, including</i></p>

	<p>applied to the rear for their safety, which was specified in the rationale provided by the Custody Sgt.</p> <p>The CISP member was also concerned that the CIC was not provided with an AA during their interview or throughout the duration of their detainment with the perception that the CIC's past was "down-played".</p> <p>Do you see evidence of this and do you think more support could have been offered to this child? Can you also verify the inspector's review regarding the UoF and advise of any learning if deemed appropriate?</p>	<p><i>the HCP updates, all efforts have been made to cater for the vulnerabilities of the DP during her detention and post detention. The custody record highlights conversation between the HCP and CAMHS, who the DP was actively involved with regarding her ongoing MH issues, and that the DP had been seen by CAMHS earlier that day and is reviewed daily by them.</i></p> <p><i>I agree that the Child Checklist is not completed adequately and lacks sufficient detail in certain areas, including VOC, and feedback has been provided to the custody officers involved.</i></p> <p><i>In relation to the UoF, the additional 12-hour inspector review does not include any focus on UoF. The purpose of this review is to assess the status of the investigation, have all enquiries been completed expeditiously, and to assess the necessity for the ongoing detention of the child. The use of force in custody is included within existing PACE reviews. The differences between the additional pilot reviews and existing PACE reviews may have caused some confusion here. The UoF in custody is acknowledged by the inspector within the 6-hour PACE review which records that UoF was used in custody in response to the DP self-harming in the cell which required force to be used to prevent her causing injury to herself.</i></p> <p><i>In relation to the observations made regarding AA provision, the DP did have an AA present for interview, processing, rights and entitlements, etc. An AA had to be sourced from local authority and arrived in custody at 11:45hrs. Following this, rights and entitlements were completed and signed by AA at midday, processing completed at 12:19hrs, and interview completed at</i></p>
--	---	--

		<p>12:41hrs. Therefore, I do not agree with the observation that "the CiC's past was downplayed" by any of the custody staff involved. There is no evidence of this within the custody record.</p> <p>However, as highlighted in previous observations above, I believe efforts could have been made to reduce the delay in arrival of the AA. The custody record states that social services would be contacted in the morning to attend as AA, but efforts could have been made to request EDT attend outside of office hours as the DP arrived following midnight. The DP's behaviour was unpredictable, evidenced in the care plan, whereby she was attempting to cause harm in the cell. However, efforts should still have been made to contact AA earlier. As already highlighted, EDT may not have been able to attend due to other commitments, but it does not appear that a request was made. Discussion regarding this will be had with the custody officer to ascertain any rationale behind this decision, which may include the aggressive demeanour of the DP posing a risk to any attending AA, and feedback will be provided.</p>
<b>Specific Case (Highlighted in Amber)</b>	<p>This CIC did not appear to be offered hygiene facilities despite being in detention for over 9 hours. The CISPC member also noted that there were a delay of an hour and a half to the 6-hour review being completed with the rationale being that they were committed and involved in an interview. Is this justified, as the perception was that the Force was to prioritise CIC in order to reduce the time children are detained in custody?</p>	<p>All detainees are provided with a list of available facilities when signing for their rights and entitlements. This list was provided to the DP at 20:09hrs following the arrival of the AA. The list states:</p> <p><i>"I understand that I can ask if I want any of the following:</i></p> <ul style="list-style-type: none"> <li>• Hygiene packs (women)</li> <li>• Food or drink</li> <li>• Washing/shower facilities</li> <li>• Reading material</li> <li>• Exercise</li> </ul>

	<p>The same child appeared to have a delay of 3 hours for custody to contact an AA after detention was authorised with no rationale provided for the delay or any details surrounding the AA attending the custody suite. More concerning was that they appeared to have been released around midnight without accommodation arrangements made. Can this be verified, and can you advise if there is any learning to be taken from this custody record?</p>	<ul style="list-style-type: none"> <li>• <i>To speak to somebody in private about any area of concern regarding my health and welfare."</i></li> </ul> <p><i>In my experience, the use of washing/shower facilities by detainees is rare despite DP's knowing that they can use them on request. On this occasion, the DP arrived in custody at 15:00hrs and was released just after midnight (just over 9hrs detention). I would argue that it is highly unlikely that the DP would have wanted to use the custody shower facilities during this time, as this would delay other processes being completed, and the DP would have preferred to use his own shower at home following release.</i></p> <p><i>In relation to the delay to the 6-hour PACE review, this was 1hr and 20 minutes late (due at 22:34hrs and completed at 23:54hrs). I note the observation that perception was that the force was to prioritise children in custody to reduce the time children are detained. The review was initially delayed as the inspector was committed in another operational matter at the time of the review being due. DPP does not operate with dedicated "PACE" inspectors, and the PACE tasks are completed by "bronze" inspectors who are also supervising all ongoing operational incidents in their BCU, as well as other BCU's, depending on resourcing. However, the DP was moved into consultation with his solicitor at 22:14hrs and so review could not have been completed at the time due. To avoid any delay to the child's release, the DP was then moved into interview and did not return from interview until 23:56hrs. A detention log entry, whilst the DP was interview, highlights that a conversation had taken place between the custody officer and inspector waiting to complete the review. Whilst a review in person is preferred, which the inspector was intending on completing following</i></p>
--	---	--

*completion of interview, it was deemed that this would only cause a delay to the DP's release as the DP was being bailed immediately after interview and would not be returning to the cell. Due to this, an "unaware" review was completed whilst the DP remained in interview as not to delay his release.*

*In relation to delay in arrival of AA, care plan, rights and entitlements section, and several detention logs on the custody record highlight that the DP did not want his father informed of his arrest or for his father to act as his AA. The DP did not have contact with his father and no longer resided with him. DP stated he previously used his grandmother, but she had moved to Italy. No other relatives could be identified and so EDT (Social Services) were requested to assist but stated that they were unable to attend until 1930hrs, which explains the delay in AA attending custody and meeting with DP. AA arrived at 19:45hrs.*

*Regarding "More concerning was that they appeared to have been released around midnight without accommodation arrangements made", detention log entries at 00:15hrs and 00:16hrs evidence that custody staff were aware that the DP was homeless, had contacted Social Services regarding the DP's housing situation at 17:00hrs when requesting that they attend as AA, the AA present was from the local authority, and the DP was released into the care of the AA who was a member of Social Services and has a statutory responsibility to locate suitable accommodation. This responsibility does not lie with police. There was no requirement to delay the child's release from custody for accommodation to be located. It is apparent that Social Services, despite being informed of the DP's housing*

		<p>status at 17:00hrs, had made no efforts to locate suitable accommodation until the time of the DP's release from custody. This information is recorded by the custody officer who released the DP following a conversation with Social Services. I agree with the custody officer's decision to release the DP from custody, preventing any delay to his release, and releasing him into the care of Social Services whose statutory duty is then to locate suitable accommodation.</p>
<b>Legal Services</b>	<p>The Panel noted on two occasions that there was either no record or it was difficult to ascertain details surrounding the contact of a solicitor arriving. Can you specify if this is correct?</p>	<p><i>In relation to the first custody record – Duty solicitor requested by DP at 14:17hrs, call centre notified by police of this request at 14:25hrs, detention log entry 14:58hrs states AA and officers are ready for interview but awaiting solicitor arrival, handover recorded at 15:26hrs states still waiting for solicitor to arrive, but then no log entry highlighting arrival of solicitor before being moved into interview at 16:09hrs. Whilst I am certain that the solicitor did arrive to represent the DP, as declining legal advice after requesting it would require the authority of an inspector, there is no log entry and the solicitor details have not been updated from "duty solicitor" in the rights and entitlements section to include the solicitor's name and firm. Panel member's observation is correct and feedback will be provided to custody officer.</i></p> <p><i>In relation to the second custody record – Panel member's observation is again correct. Solicitor notified at 00:33hrs but there is no entry prior to interview regarding solicitor arrival or consultation. However, the rights and entitlements section has been updated with solicitor name and firm.</i></p>

		<p><i>This may require force-wide comms to all custody staff reminding them of the importance of documenting solicitor arrival time and transfer of detainees for solicitor consultation.</i></p>
<b>Female CIC</b>	<p>It could not be determined whether the female officer assigned to the female CIC introduced themselves. Can this be validated?</p>	<p><i>I can confirm that there is no entry relating to the assigned female officer introducing themselves to the detainee. On this occasion, the DP was only in custody for a very short period before being released into the care of her mother and grandmother.</i></p> <p><i>However, I believe that this is an area that could be improved upon generally across the force and will continue to monitor in the coming months. The priority in recent months has been to first improve compliance regarding female officer allocation before pushing for additional improvement in this area.</i></p>
<b>Arrest necessity</b>	<p>Two records solely specified the arrest necessity '<i>To conduct prompt and effective investigation</i>'; the others had additional necessities. Those two records involved CIC in detention for 7 hours 35 minutes and 20 hours and 24 minutes. Can you advise whether the necessity specified alone justified the CIC detainment?</p>	<p><i>In relation to the first custody record – The offence under investigation on this custody record was drink drive and so “prompt and effective investigation” would be the only required Code G necessity to obtain two evidential specimens of breath via an approved device at custody. The DP arrived in custody at 23:26hrs, providing positive evidential samples of breath at custody, and so required a period of rest for sobriety to return before being charged. This provides the explanation for the length of detention being 7 hours 35 minutes.</i></p> <p><i>In relation to the second custody record– This custody record has a total of 4 necessities listed. These were “prompt and effective investigation, prevent person causing loss or damage to property, prevent person causing physical injury, protect child or other vulnerable person”.</i></p>

		<p><i>On both occasions detention was both necessary and proportionate.</i></p>
<b>Total Time in Custody</b>	<p>The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 2 hours and 14 minutes. In comparison to last year's report this was 14 minutes which is an increase of 2 hours.</p> <p>This lapse has been contributed with the longest delay being 12 hours and 29 minutes, due to the transportation of a CIC from an out of force area into DPP. Can you advise whether it was proportionate for this CIC to have made this commute?</p> <p>The second highest waiting time was 3 hours and 18 minutes, with the CISPM member unable to determine a rationale for the delay. Can you verify the reason for the delay and identify if you think it was justified?</p> <p>The shortest time a DP was held in custody was 1 hour and 49 minutes. The arrest necessity was <i>To conduct prompt and effective investigation of the offence and To prevent physical harm to themselves or other</i>. Do you assess that this CIC, who was detained for less than 2 hours, was proportionate and necessary to be brought to custody?</p>	<p><i>I suspect that this data regarding average time is incorrect and may need to be revisited.</i></p> <p><i>On review of the first listed custody record, the time recorded by the panel member of 12 hour and 29 minutes is the time difference between time of arrest and time of arrival at custody, not time of arrival and time of detention authorised. The DP was arrested in Met Police force area at 20:12hrs on 08/09/25 and arrived in custody in DPP at 08:40hrs on 09/09/25 (12 hours 28 minutes). The actual time lapsed from time of arrival (08:40hrs) and time detention authorised (09:02hrs) was 22 minutes. This misinterpretation of timings will have adversely affected the average time recorded in this report as the time recorded by the panel member is 12 hours and 6 minutes greater than the correct time. Arrest in one force area and transport to custody in another force area is not uncommon. On this occasion, all five of the offences were serious in nature and had been committed in DPP force area. However, the DP had since relocated to London and so was arrested by Met Police. On occasions such as this a decision must be made by the investigation team, taking into account the needs of the investigation and the initial 24-hour PACE clock, whether to travel out of force to conduct the interview or to convey the DP to custody within DPP. This is complicated by the intricacies of the legislation regarding the PACE clock which are too difficult to explain within this report. However, I am happy to discuss and explain this in greater depth with panel members at the next scrutiny panel.</i></p>

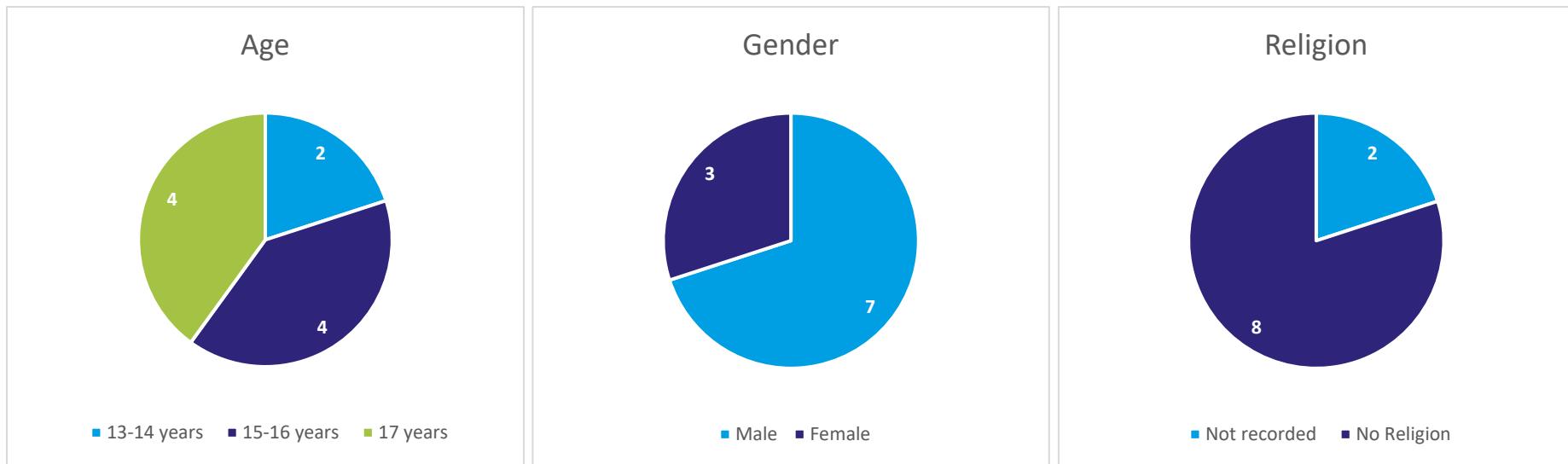
*In relation to the second custody record – The delay on this occasion was the result of a human admin error by the custody officer booking the detainee into custody. The delay between arrival and detention authorised was 3hrs 18mins. The “booking in” section was signed by the following custody officer after receiving a handover at 0023hrs. This is also accompanied by a detention log entry which highlights that the box was not signed in error by the previous custody officer. Feedback has already been provided to the custody officer who forgot to sign when authorising detention.*

*In relation to the third custody record – I have checked this custody record and the detainee was detained for 16 hours 39 minutes with a total of 3 necessities listed which were “prompt and effective investigation, prevent the person suffering physical injury, and protect a child or other vulnerable person”. This appears to be a recording error by the panel member. I have checked for any additional events that may have caused confusion such as the DP returning on bail at a later date, but the DP was released NFA at the end of the custody episode. This error in recording may in fact mean that the average detention time is higher than recorded.*

# Annex- Custody Record Review Findings

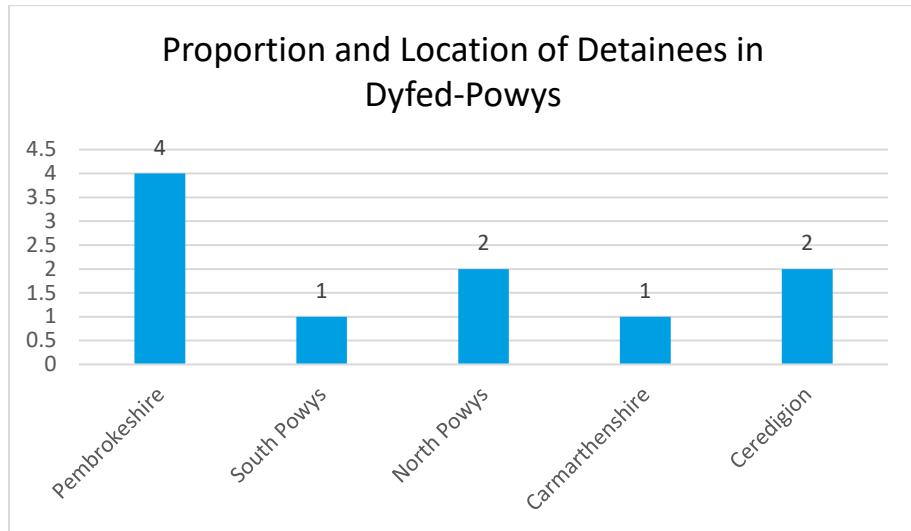
The data below outlines the results of the feedback forms completed by the Panel members which was analysed to identify the positive and areas requiring improvement in each specific area of custody with the focus of CIC. This section of the report is supplemental to provide context to the Summary of Findings and the Panel Observations sections above.

## Demographics

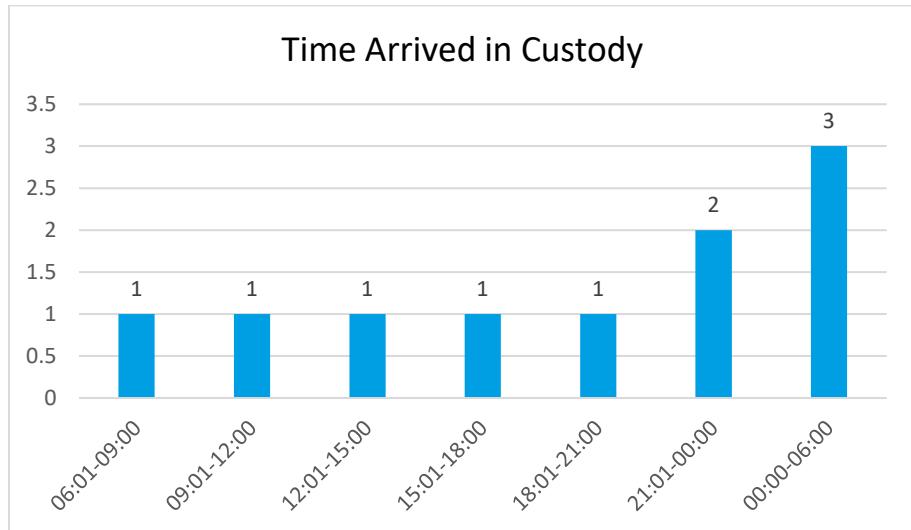


- Ethnicity for all CIC records viewed were recorded as White British for this dip sample.

## Custody Suites



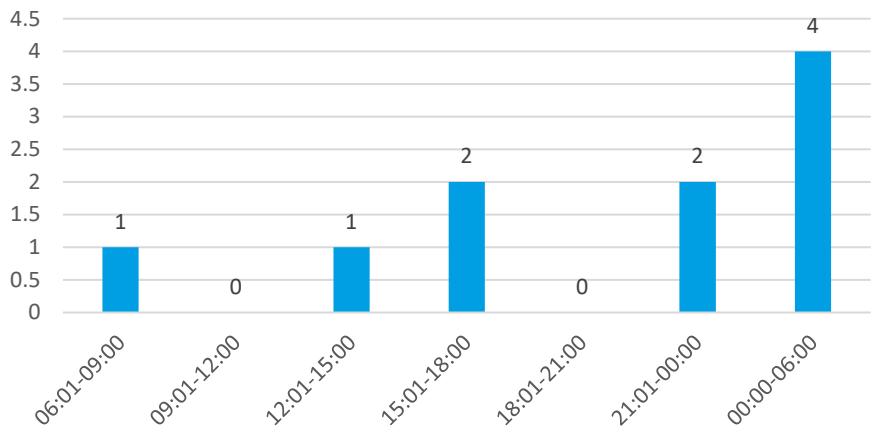
## Time Arrived in Custody



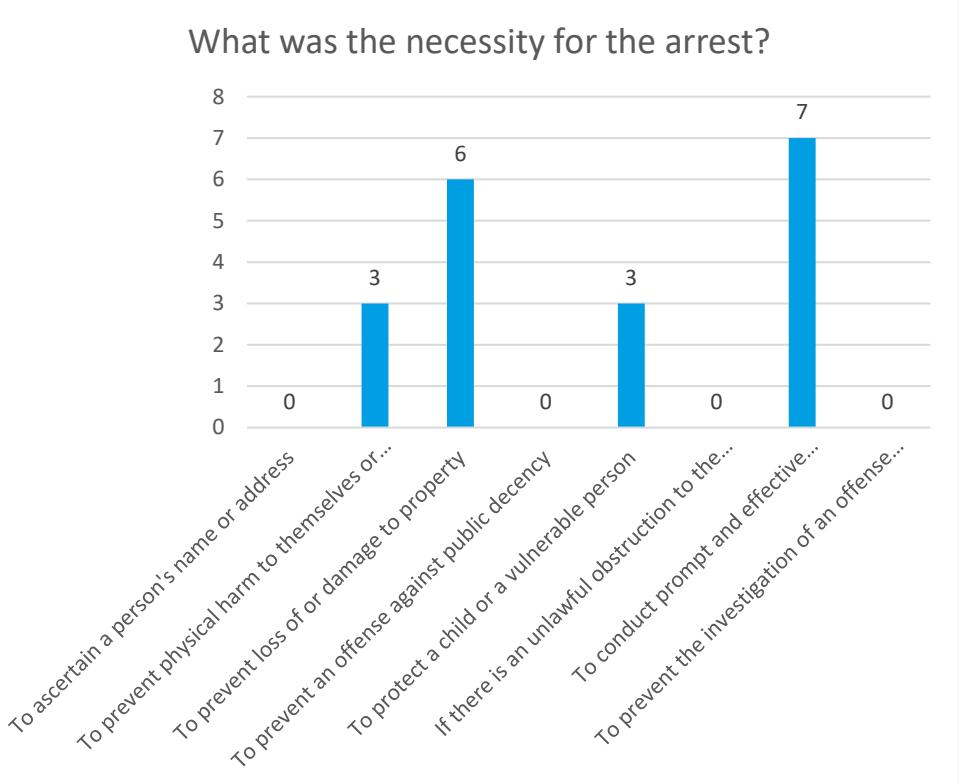
## Time Lapsed From Arrival to Detention Authorised

- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 2 hours and 14 minutes.
- The highest waiting time was 3 hours and 18 minutes with the Panel member unable to determine a rationale for the delay.
- The fastest time for a detained person (DP) to have their detention authorised was 4 minutes.

### Time Authorised in Custody



### What was the necessity for the arrest?



5

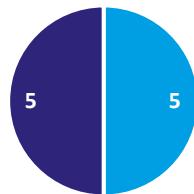
### Total Time in Detention

- The average time a detainee was held in custody was 4 hours and 41 minutes.
- The longest time a DP was held in custody was 1 days and 24 minutes.
- In contrast, the shortest time a DP was held in custody was 1 hour and 49 minutes.

- The Panel were asked to ascertain the necessity for the arrest. The list of necessities under PACE are:
  - To ascertain a person's name or address
  - To prevent physical harm to themselves or other
  - To prevent loss of or damage to property
  - To prevent an offence against public decency
  - To protect a child or a vulnerable person
  - If there is an unlawful obstruction to the highway
  - To conduct prompt and effective investigation of the offence
  - To prevent the investigation of an offence or the prosecution of the suspect being hindered.
- The most prominent arrest necessity identified was *to conduct prompt and effective investigation of the offence* followed by *To prevent loss or damage to property*.
- Two records solely specified the arrest necessity *to conduct prompt and effective investigation*; the others had an additional necessity. Those two were in detention for 7 hours 35 minutes, 20 hours and 24 minutes.

## Provisions in Custody

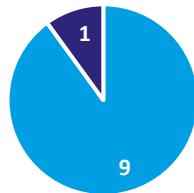
Were religious requirements catered for?



■ No ■ N/A (due to no religion)

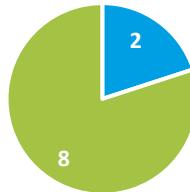
- From the previous CISP report on use of force, the CISP were reminded that religion does not currently form part of the risk assessment question set since the introduction of Niche and this is unlikely to change in the immediate future which sits outside of DPP's autonomy. It is also not a mandatory field that needs to be completed and so this means that it can be missed on occasion. Religion is now captured in the detainee's name & information section of the custody record; therefore, to rectify this, CISP members are consulting with the Inspector at the meeting, who has access to the full Niche custody record, to validate if it has been captured.

DP was asked about dietary requirements and allergies?



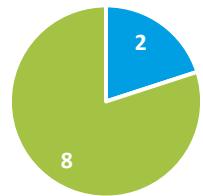
■ Yes ■ No

Was the DP instructed in the use of the cell call bell?



■ Yes ■ No ■ No details found in record

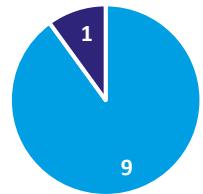
Was the DP instructed that the toilet is pixelated?



■ Yes ■ No ■ No details found in record

- The individual who was not offered food and refreshment or dietary requirements was not specified in the custody record due to their detention being less than two hours.
- The CISPs are still finding no record detailing toilet pixelation nor details where DPs are being instructed of the cell call bell in the records they scrutinise.

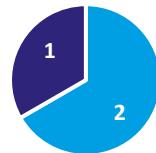
Food and refreshments offered regularly?



■ Yes ■ No

## Female Detainees

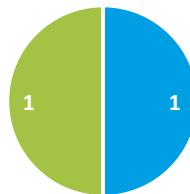
Was a female officer assigned where necessary for a female DP?



■ Yes ■ No

- Of the 3 Female DPs were asked whether they would like to speak with someone from the same sex and they were all offered menstrual products.

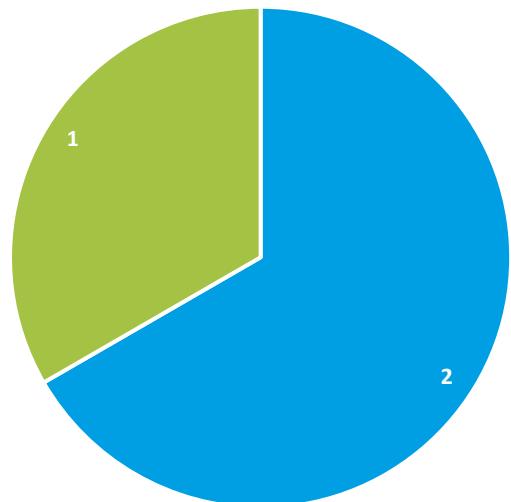
Did a female officer introduce themselves to the DP?



■ Yes ■ N/A ■ No details found in record

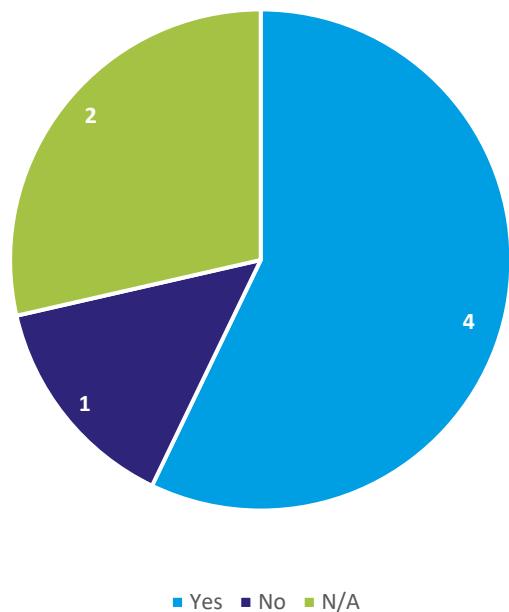
## Hygiene

(For Females) Does the record make any reference to hygiene requests being made/given, for example; showers and handwashing facilities being offered?



- It was noted that the single female CIC was not applicable to be offered hygiene facilities due to their detainment only consisting of less than two hours.

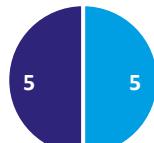
(For Males) Does the record make any reference to hygiene requests being made/given, for example; showers and handwashing facilities being offered?



- It is not clear why one male was not offered hygiene facilities; this will be added in the *Panel Observations for clarity*.
- One CIC was not deemed applicable as they were travelling from another Force area to be brought to a DPP custody suite.
- It is not clear why an additional N/A was selected by the CISPC member for the other CIC.

# Rights and Entitlements

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



■ Yes ■ No

- All rights were provided to CIC either at booking in or at a later stage in the CIC detention.

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

- The average time for a detainee to request a solicitor was 1 hour 57 minutes.
- Only 1 record of the 10 viewed, the CIC declined the option to request a solicitor.
- The longest period for a DP to request a solicitor was 10 hours and 13 minutes.
- In contrast, the shortest was immediate into the authorising of their detention.

## The length of time taken for police to contact a solicitor

- The average time taken was 1 hour and 49 minutes for police to contact an on-duty solicitor.
- The longest period of time was 10 hours and 36 minutes.
- The shortest was 8 minutes.

Did the DP see or speak to a Solicitor?



■ Yes ■ No ■ No details found in the record ■ N/A

If there was a lengthy delay in seeing a solicitor, was there any rationale available?

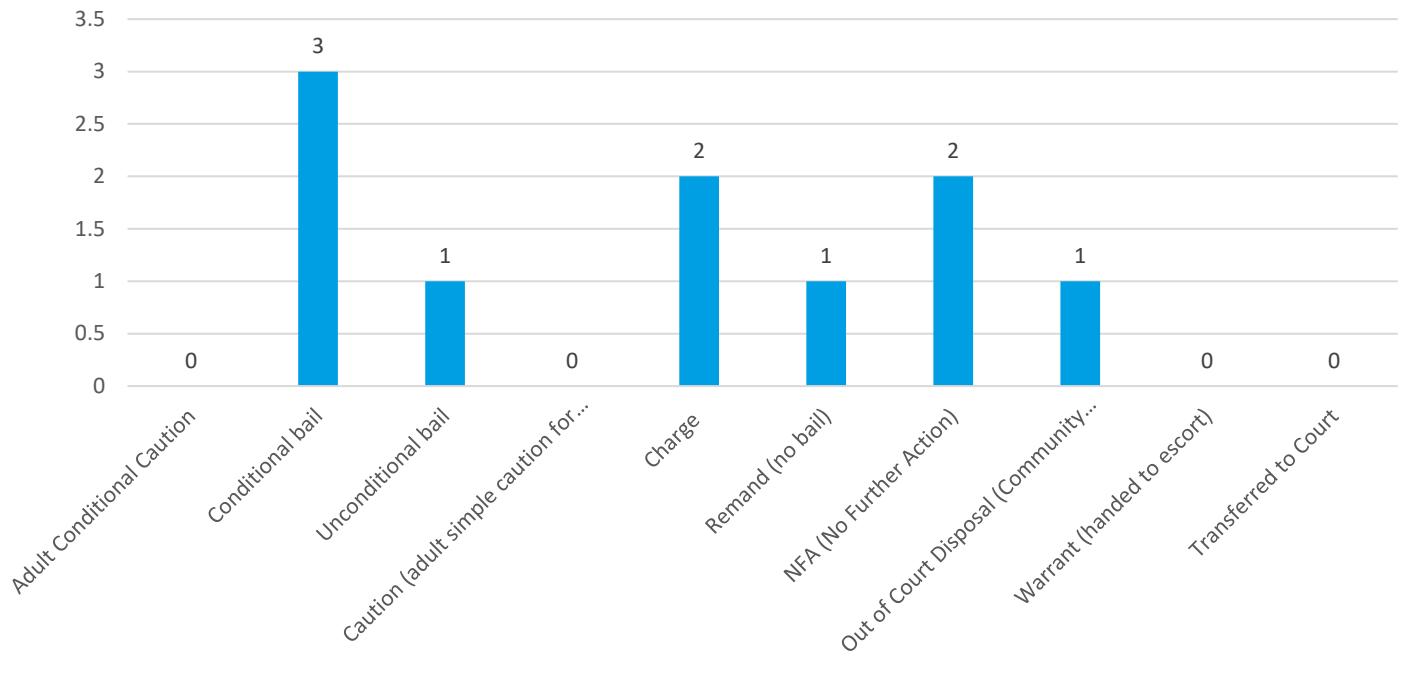


■ Yes Rationale Given ■ No Rationale Given ■ N/A

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

- The average time it took for a solicitor to arrive after being requested was 4 hours and 7 minutes.
- The Panel noted on two occasions that there was either no record or it was difficult to ascertain details surrounding the contact of a solicitor arriving.
- Of the 6 CIC that saw a solicitor, saw them in person.
- The Panel made the following observations on the delays in solicitor's seeing the CIC as recorded in the custody record:
  - 1) The delay could have been attributed to the unavailability of an AA.
  - 2) On two occasions the CISPR referenced that once the solicitor was contacted, there was no record of them arriving at custody.

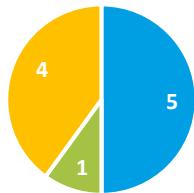
### What was the disposal method?



- The Panel were asked to note the disposal method to assess whether the CIC's detainment was proportionate to the necessity of arrest.
- The highest disposal method was for conditional bail which is the process that allows officers to attach conditions to bail which may support victims and/or witnesses, preserve evidence and mitigate further crime.
- Of the two records with the disposal method being NFA, they were detained for 15 hours and 12 minutes and 16 hours and 35 minutes, with the arrest necessity specified for both of them '*To prevent loss of or damage to property*'; and the other '*To prevent physical harm to themselves or other*'.

## Observation Level

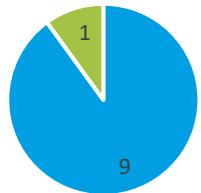
What Observation level was set?



■ Level 1 ■ Level 2 ■ Level 3 ■ Level 4

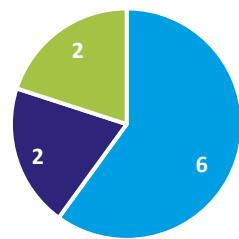
- All custody records reviewed had their observation level set.
- The risk level is judged on 4 levels.
  - Level 1 General (at least once every hour)
  - Level 2 Intermittent (every 30 minutes)
  - Level 3 Constant (constant observation CCTV and accessible at all times)
  - Level 4 Close Proximity (physically supervised in close proximity).
- Of the single records that was deemed Not Applicable (N/A) this was due to the CIC being detained for less than two hours.

Was the observation level adhered to?



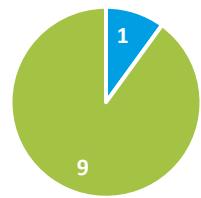
■ Yes ■ No ■ N/A

Was the DP on rousal?



■ No ■ N/A ■ No detail

Was this adhered to?  
(Including the 4Rs)

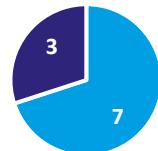


■ Yes ■ No ■ No detail found in record

- Two Panel members could not find detail to advise if the DP was on rousal. In police custody, rousing checks are mandatory for detainees under the influence of drugs or alcohol and is only applicable for detainees who are under Level 2 observations.
- The Panel made the following comments in relation to the observational levels:
  - 1) *"The Custody Sgt has assessed the level as 4 for observations. However, on inspector review it appears that the assumption has been made that DP is on Level 1. The custody staff are clear that its Level 4 and undertaking these checks with AA also present. It is concerning that Inspector has not looked at the whole custody log to see the level 4 or have only looked at the medical level 1. Custody Sgt has made clear from arriving at Custody suite level 4. Following the inspector review still on level 4. No evidence of any change"*
  - 2) *"Observation level was set at Level 4 until strip search had been conducted, then reduced to Level 1 which appears to have been adhered to."*
  - 3) *"Level was dynamic and some rationale each time for it being dynamic."*

## Support Services

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



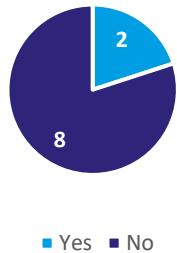
- Panel members specified that within 3 records, CIC had declined the option of support services.
- The CISP members stressed that the primary service offered to CIC were for Social Services regarding accommodation, mental health and for safeguarding purposes.

Is there any evidence of contact with support services/Mental Health Team/or reasons provided for no contact?

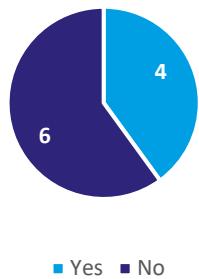


# Healthcare Professional (HCP)

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



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



- The CISP validated that all CIC saw a HCP.
- The CISP noted the following observations in relation to HCP provision:
  - 1) One member queried whether the disclosure of self-harm was taken seriously when it was reported on two occasions by the CIC.
  - 2) *"The evidence showed they were down played in custody, however, due to her troubled lifestyle she was probably failed in the community by services and custody last resort. This period in custody did not benefit this young person and Child gravity matrix used and NFA. She was risk to herself but custody not the right place. More community services needed for this young woman".*
  - 3) *"A female officer allocated would have been appropriate for this child on level 4. May have been better for her mental health needs."*

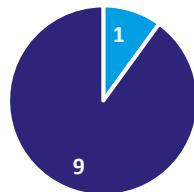
---

## Special Risk Clothing (SRC)/Anti-Rip Suites

- There were no instances of CIC wearing a SRC. This is due to DPP taking the decision to eradicate SRC as of May 2025.
- In no instance were the clothing removed by Force.

## Use of Force

Was force used in the custody suite?

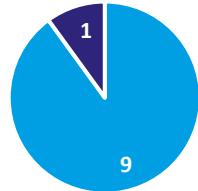


■ Yes ■ No

- In relation to the single custody record which force was used in custody, handcuffs were applied. The CIS member deemed this an appropriate measure due to the CIC attempts to self-harm with the accompaniment of Level 4 observations to ensure the CIC safety. There were no injuries to the CIC nor the staff involved.
- The only concern pertaining to this record is specified by the CIS member below:  
*"There is concern that the Inspector's review did not refer to use of force in custody and in review at 12 hours said no force had been used. Used in cell with handcuffs behind back on level 4 to a young woman. It should have been in the review. The juvenile did not have an AA through the interview and had no independent person in the cells with her. This was justified in that she was ready for NFA yet AA not arrived and she had been in custody for 17 hours."*

## Strip Search

Was there a good rationale for strip search?

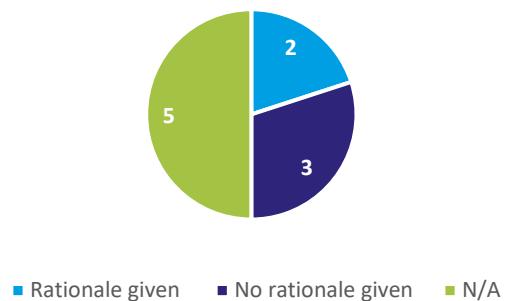


■ DP not strip searched ■ Yes

- Of the single record that recorded a strip search on a CIC, the CISP member identified that an Appropriate Adult (AA) was present during the process.
- They noted that the CCTV was recording but the camera was switched off for the dignity of the search.

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

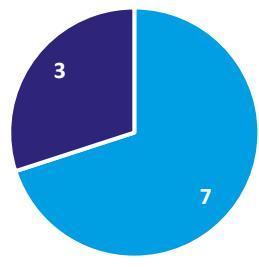
Was there any rationale available for a delay in AA's arrival?



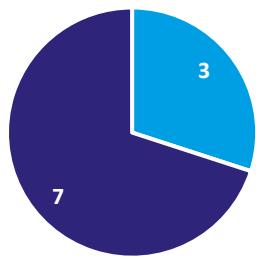
- The Panel noted the following reasons other than being a child, why the CIC had additional vulnerabilities:
  - Three instances of being neurodivergent.
  - Being homeless.
  - Two instances of Self-harm and suicide risk.
  - Foetal alcohol syndrome.
  - Two instances of Mental Health including depression and PTSD.
- In all records reviewed, the Force identified that an AA was required and all nominated persons were contacted.
- The average time that it took for police to contact an AA was 2 hours and 35 minutes.
- The average time first contact was made between the CIC and the AA was 4 hours and 16 minutes. In three instances, there was no rationale provided for the delay.
- The Panel specified three instances where the delay for an AA was due to Social Services not working out of hours.

## Children in Custody

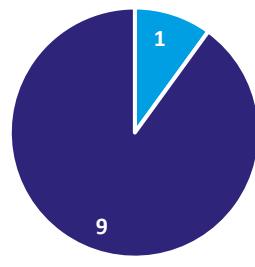
Was the Children in Custody checklist used?



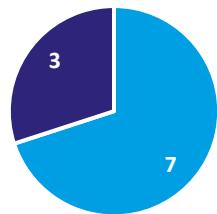
Was the Voice of the Child recorded?



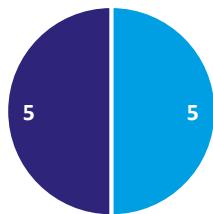
Has a reachable moments interview occurred?



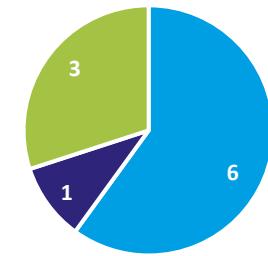
Has there been an Inspector's review within 1-2 hours of the child detained?



Has the arrest been reviewed by the Sergeant (not Custody Sergeant)?

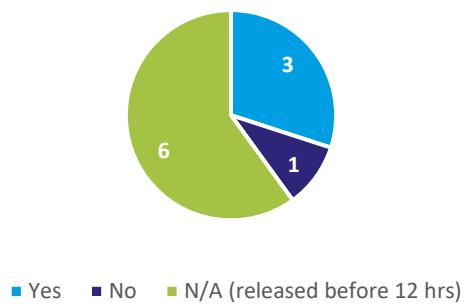


Has the 6 hour PACE review been completed?

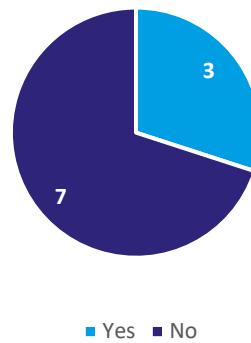


■ Yes ■ No ■ N/A (released before 6 hours)

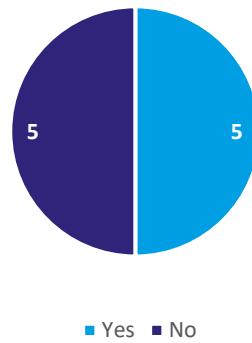
Has the third Inspector review taken place (12hour PACE clock for children)?



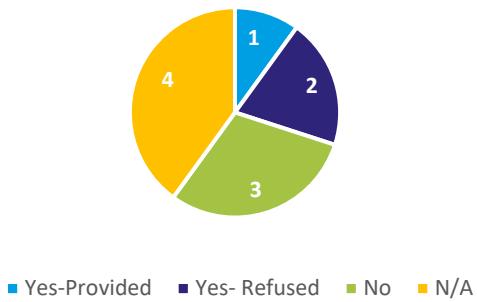
(Children only) Was the child charged?



(Children only) Was the young person detained overnight?



(Children only) Was an alternative care setting sought?



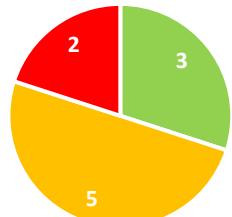
- There was one custody record where the 2 hour review was logged 2 hours afterwards by the inspector and the 12-hour review, was provided by the inspector in the 15 hour review.
- Of those 3 records that alternative accommodation was not sought, for two instances, this was due to the time of day the CIC was detained (detained throughout the day), and the latter was detained for 4 hours.
- The CISPs had the following comments in relation to Childrens Checklist:
  - *"I am concerned that a child appears to have been released around midnight with no obvious accommodation."*
  - There were four references specifying that they were unable to view the Voice of the Child.
  - A Custody Sergeant has recorded a lot of information on the Children's Checklist and appears to have taken time to explain matters to the child, and to discourage further misuse of alcohol.
  - *"The case record did not read as if it was a juvenile. The Childrens checklist was present, but poor".*

## Red Amber Green (RAG)

At the end of each custody record reviewed, the Panel were asked to review the below criteria and assess their overall grading of the custody record using the RAG rating:

Examples of Reason for Rating	Follow Up Action
<b>Full rationale provided for use of force, strip search or and for any delays from external agencies supporting detainees which are both justifiable and proportionate.</b>	No further action required at this point.
<b>All Rights &amp; Entitlements have been provided to the detainee.</b>	
<b>Clear de-escalation, distraction items etc. used to mitigate risk of detainee DSH.</b>	
<b>Little or unclear justification for the use of the Anti-Harm Suit, use of force or strip search.</b>	Advice/further training given to custody staff.
<b>Insufficient information to determine any delays in the detainee receiving their rights for legal representation or an appropriate adult.</b>	
<b>Inconsistent recording of Rights &amp; Entitlements.</b>	
<b>No rationale or justification is not proportionate.</b>	
<b>Decisions made in the absence of risk information and with no other rationale.</b>	Further exploration required in relation to lack of rationale. Cases to be raised with custody inspector.
<b>Significant delays in detainees seeing HCP, legal services or an appropriate adult.</b>	
<b>No apparent consideration for detainee's vulnerabilities.</b>	

RAG Rating



■ Green ■ Amber ■ Red

The rationale assigned to each colour grading were of individual Panel member's assessment/judgement of the custody record they were assigned to. Below are some of the rationales the Panel provided for their grading:

Green	Amber	Red
<p><i>"In custody shortest possible time. Mother (was the) AA. Reviews (were) on time".</i></p>	<p><i>"Overall record shows good care of this child whilst in custody. Only issue is that 6 hour review was not carried out on time an hour and a half late. Rationale was given that review was delayed due to heavy commitments in custody and were involved in another matter prior to interview. I was under the impression that Children in Custody would be prioritised."</i></p>	<p><i>"This juvenile Appears to have slipped through several safety nets and a complex case as to safeguarding self harming. Care by custody staff was good but processes and other services let her down. This could not have been a positive outcome for this young person and wanting to self harm and not having support of AA early. She self harmed in custody and needed some intervention on leaving. Where these issues could be highlighted they were missed in Inspection review and Health assessment. She is vulnerable and ultimately NFA so could she have been dealt with differently from the start. The Childrens checklist is poorly completed".</i></p>
<p><i>"Short stay in custody and helped to leave asap. Maybe some clearer</i></p>	<p><i>"There was no explanation of the delay between arrival in custody and the</i></p>	<p><i>"I feel that this child should have had a female officer allocated to her, she was particularly vulnerable."</i></p>

<i>evidence that the check list used but the info in care plan thorough."</i>	<i>authorisation of detention (3 hours 31 mins)".</i>	
<i>"Child dealt with appropriately. Arrest was necessary to prevent harm to others, but continued detention was not, and the child was released under investigation."</i>	<i>"Concern about the Level 4 rating but Inspector thought it was level 1. Confusion that could have implications. Also was self harm considered seriously enough as self reported by DP".</i>	