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December 5th 2024

Police and Crime Commissioner for Dyfed-Powys Authored by: Tom Walters Custody Independent Scrutiny Panel:
Women & Girls in Custody

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# Overview, Background, Purpose and Methodology

The origins, purpose and the rationale for the Custody Independent Scrutiny Panel (CISP) can be found on our webpage and specifically under the Terms of Reference (ToR) via this link: <a href="Dyfed-Powys Police & Crime Commissioner">Dyfed-Powys Police & Crime Commissioner</a>

In August 2023, the Mayor of Greater Manchester commissioned Dame Vera Baird to carry out an independent Inquiry into the treatment of women and girls who have been arrested and taken into police custody in Greater Manchester. This came following a <u>Sky News investigation</u> in July 2023 that reported distressing incidents regarding the cases of three women who were arrested and detained by Greater Manchester Police (GMP). The volunteers were made aware of the subsequent <u>Dame Vera Baird Inquiry Report</u> that was released on 18<sup>th</sup> July 2024.

Within the report, it specifically focused on the appropriate use, or otherwise, of strip searches and intimate searches, including the removal and replacement of clothing. 14 case studies were included within the report detailing the experiences of 11 women & girls and 3 men with Great Manchester Police, from the period before arrest, during arrest, detention and post-detention.

The report highlights a number of concerns and failings by GMP including:

- Unlawful arrests
- · Unnecessary use of force
- · Lack of adherence to the victim's code
- Not assigning female officers to female detainees
- · Lack of a trauma informed response when dealing with victims of sexual and domestic abuse
- Lack of providing sanitary products to female detainees.

- · Delays in responding to cell buzzers
- Inappropriate use of strip searching
- Inconsistent and inaccurate record keeping within the custody records
- Delay and lack in providing medical care to injured detainees
- · No reasonable adjustments for a disabled detainee
- Culture and attitude of officers and custody sergeants being taunting and biased & complaints being handled by those who's allegations are against

The College of Policing Director of Operational Standards, Assistant Chief Constable Tom Harding stated this after the report:

"Every person who comes into contact with the police must be treated with dignity and respect. This is the foundation upon which trust and confidence is built and without this, we cannot effectively serve the public.

Dame Vera's report makes for difficult, but necessary reading. Today, Greater Manchester Police has apologised to those given a voice by the inquiry, who did not receive the care and consideration they were entitled to and the force has committed to implementing the recommendations in full.

I understand that the contents of this report will cause further concern regarding the treatment of women and girls. I want to reassure all women and girls that your safety, trust and confidence remains a priority for the College of Policing, across all of our work.

Dame Vera recognises the importance of the College of Policing's guidance being implemented by all forces. Our guidance sets out important considerations to help determine if an arrest is necessary and how to care for those in custody, including those who are vulnerable and those with complex needs.

Custody is one of the most complex and high-risk areas of policing. In order to support officers and staff we have invested in new immersive training which puts them in a live custody environment with real life scenarios, dilemmas and decisions that affect the safety and wellbeing of detainees."

We have already been working with Greater Manchester Police as they have sought to quickly learn lessons and improve their policies and practices. We're also supporting forces across England and Wales to strengthen their custody practices, so that every single person who comes into police custody is treated with respect and empathy.

I am thankful to Dame Vera Baird for her thorough inquiry. We will now work across policing to respond to the findings and recommendations in her report."

As a result of the publication of the Vera Baird Inquiry report, the Panel were asked to:

- Seek assurance that female detainees are allocated a female welfare officer upon arrival and that their needs are catered for (such as the offering of sanitary products).
- Assess whether all custody records reviewed are accurately recording events of a strip search.
- Establish the rationale associated with any strip searches conducted on any female detainee.

Here is an example of the set of questions the Panel were asked to consider:



# **Summary of Findings**

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

# **Positives:**

#### **Strip Searches**

Of the 11 custody records reviewed, 9 were not subjected to a strip search. The one that had recorded a strip search, provided a rationale and an Appropriate Adult (AA) during the process. There was one record where the Panel member could not determine whether a strip search had been conducted (please see Force Observations for this).

#### **Hygiene and sanitary products**

9 out of the 11 records show that hygiene products (including handwashing products) and shower facilities were provided to female Detained Persons (DPs); and, menstrual products were offered to all female DPs.

#### Speaking with someone of the same sex

All female DPs were asked if they would like to speak to someone of the same sex.

## **Special Risk Clothing (SRC)**

No female DPs was subjected to wearing a SRC (also known as an Anti-Harm suite) in this scrutiny panel dip sample.

### **Total Time in Custody**

The average time a detainee was held in custody was 16 hours and 49 minutes, with the average authorisation into detention being 23 minutes.

# **Healthcare Professionals (HCP)**

All except one detainee saw a HCP without any delays.

### **Improvements in recording of Rights & Entitlements**

All DPs were asked about their dietary requirements and were offered food and refreshments regularly. 55% were informed of religious items & instructed on the in cell call bell, 36% were informed that the toilet is pixelated in the CCTV and all DPs received their Rights & Entitlements either at the booking in stage or later into their detention.

# Appropriate Adults (AA)

The Force identified that AA was required and was requested for all juvenile detainees in this dip sample. In conjunction, all nominated people were contacted and a rationale for an AA was adequately provided. The average time for a detention officer to make contact with an AA was 1 hour and 1 minutes, and the average time the DP first made contact with an AA was 1 hour and 26 minutes.

# **Areas for improvement:**

#### **Assigned Same Sex Officers**

The Panel assessed that within two records, they could not ascertain whether a female officer had introduced themselves to the female DP.

# Gaps in information recorded across custody records.

There were a number of instances where the Panel noted:

- Three occasions where there was no record between the DP requesting and solicitor arriving at the custody.
- Three records did not display a rationale for the delay in the DP seeing a solicitor.
- No detail of an address a juvenile DP was released to.
- 6 records did not include whether the DP were instructed on the Cell Call bell.
- Two records show no detail of the observation level.
- Four instances where there was no evidence that support services were provided or contacted.

# **Support Services**

• 46% of DPs were offered support services in comparison to 36% who were not. As part of Dame Vera Baird's Inquiry report, recommendations included greater awareness of trauma informed services specifically to those who suffer with

Domestic Abuse or are victims of Rape and Serious Sexual Offences (RASSO). There are also other types of support that include substance misuse, Mental Health services, or signposting to the new <u>Women's Centre</u> in Carmarthen.

#### **Voice of the Child**

Of the 11 records reviewed, 6 of those were juvenile DPs. Only 2 of the 6 records involving juvenile DPs contained details for the Voice of the Child. (Please see Force Observations for further information on this).

# **Panel Observations**

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

Theme	Observation	Force Response
Female officers assigned to DP	The Panel assessed that within two records, they could not ascertain whether a female officer was assigned to a female DP.	Both records were checked and a female officer had been assigned on both occasions.
Female officers introducing themselves to the DP	Within 6 of the records, the Panel could not determine whether a female officer had introduced themselves to the DP.	On four of the records, the female officer was a member of custody staff, either the Detention Escort Officer (DEO) or Police Sergeant (PS), and so would have introduced themselves at the custody desk.  However, within two of the records, whilst a female officer had been allocated, there is no record of that officer introducing themselves.
Missing information	Within one custody record, the following information was not prevalent to the Panel member: - instructed in the use of the cell call bell - DP instructed that the toilet is pixelated -Did the DP see or speak to a Solicitor and no apparent rationale in any lengthy delay in seeing a solicitorNo evidence that support services were contacted or signposted.	I reviewed this custody record and I believe that this particular record may have been slightly confusing for the reviewer. The DP was booked into custody for a short period of time but then bailed to return the following day for interview. The rationale provided for this was that due to this DP being a juvenile, the emphasis was to reduce the time spent in custody and to not conduct an interview during the early hours of the morning. In answering the points raised:

	- No detail provided of when AA arrived at custody unitNo details of the address that the detainee was released to.	<ul> <li>No entry regarding use of cell bell or that toilet is pixelated.</li> <li>DP did not speak with solicitor during initial custody visit as interview did not take place. However, numerous entries present on return the following day highlighting the solicitor arriving at custody, having consultation and being present during interview.</li> <li>No entry found regarding support services.</li> <li>AA arrived at custody during initial visit at 2124hrs and on second visit AA arrived at custody to answer bail with DP.</li> <li>No entry regarding address DP released to. However, DP would have been released to her home address as the address was not where the offence took place.</li> <li>Feedback will be provided to custody staff by each Base Command Unit (BCU) Custody Inspectors.</li> </ul>
Observation Level	Within two custody records, it could not be determined of the observation level.	On both records the observation level is included in the care plan endorsement and is Level 1 with 30 minute interval observations.
Strip Search	One Panel member could not determine if a Strip Search had been conducted.	There was no entry regarding a strip search being conducted. However, the fact that this is not present does not highlight any error on the part of

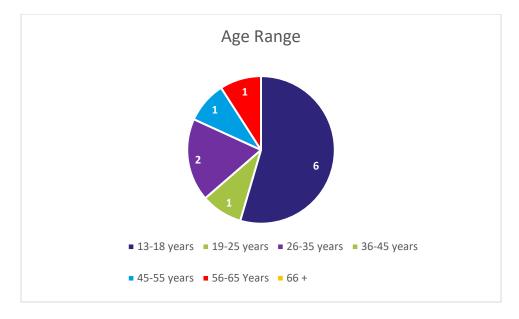
		the custody officer. A strip search entry/form would only be created IF a strip search could be justified and was actually conducted.
Voice of the Child	Four records involving juvenile DPs did not have Voice of the Child recorded.	I can see that 1 of the 4 records highlighted by the panel did have a "Voice of the Child" entry; however, the other 3 records did not. This is an area where the compliance rate will need to be monitored and feedback will be provided by each of the BCU Custody Inspectors.
Reachable Moments	None of the records reviewed for juvenile detainees showed any evidence in recording reachable moments	Reachable moments are included within the Child in Custody Checklist; however, Reachable Moments are not being updated throughout the detention period. This is a piece of work that will be taken forward by Insp Rogers as Reachable Moments should not be being completed by custody staff. A process needs to be implemented where this is completed by a suitably trained professional who has the appropriate training to support children in custody.

# **Custody Record Review Findings**

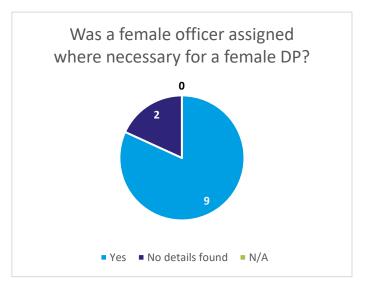
The data below outlines the results of the feedback forms completed by the Panel members which was analysed to identify the positives and areas requiring improvement in each specific area of custody with the focus of Women & Girls in custody.

#### **Demographics**

- As referenced in the title, the demographic specifically is focussing on women and girls in custody; therefore no males were considered for this scrutiny activity.
- All 11 records that were scrutinised were recorded ethnicity as White British.

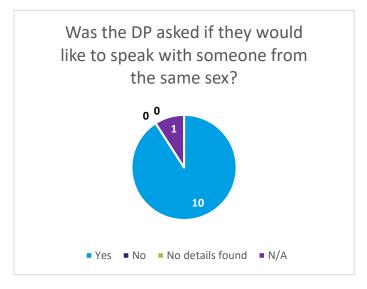


#### **Female Detainees**





• The Panel member that specified N/A, noted that the female DP was very intoxicated and required HCP assessment due to banging her head in the police van. DP was given time to sleep in order to sober up; therefore, would not have capacity to recall an introduction from a female offer.



# **Hygiene Requests**

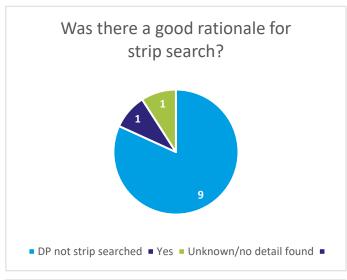
Does the record make any reference to hygiene requests being made/given, for example; showers and handwashing facilities being offered?

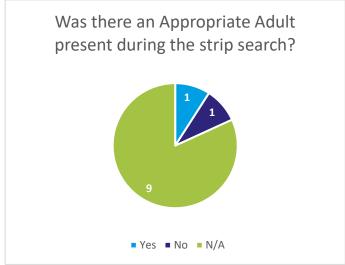


- The Panel overall assessed that the hygiene coverage was good, that information leaflets were handed to the DPs and all risk questions were asked.
- For those listed as not applicable (N/A), one Panel member noted that the juvenile was only in detention for 2 hrs 27 minutes.
- From the 11 records reviewed, all females DPs were offered menstrual products.

# **Stip Searches**

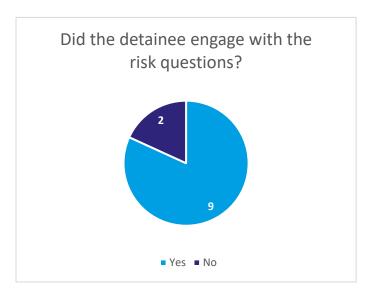
- Of one DP that was strip searched, the Panel member recorded that they had provided a good rationale for doing this and Appropriate Adult was present during the process.
- There was one record where it could not be determined if a strip search had been conducted or not.

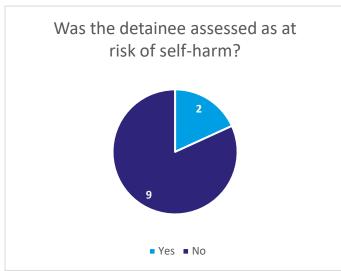




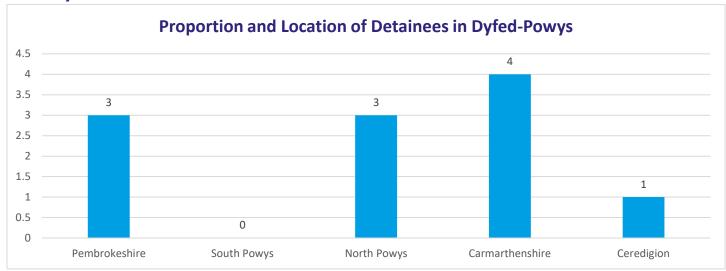
# Special Risk Clothing (SRC) formerly known as Anti-Rip Suites

• Of the 11 custody records reviewed, no detainee was provided with SRC and no clothing was removed by Force.

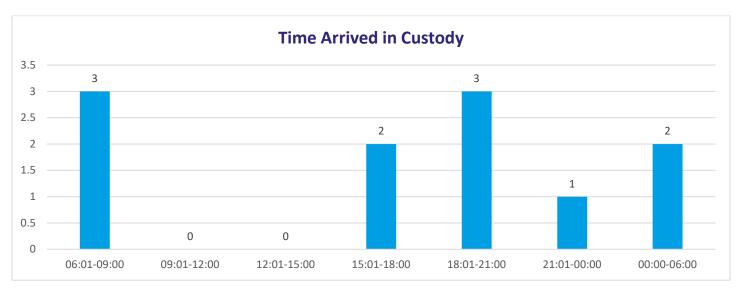




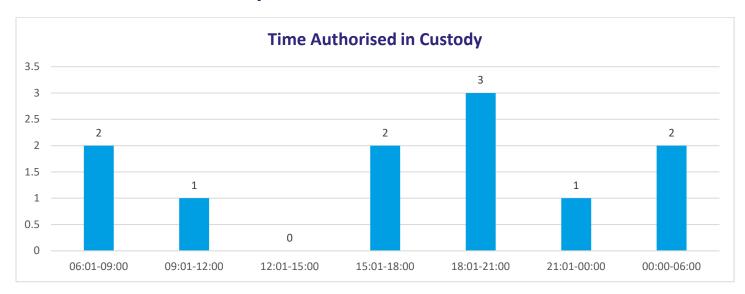
# **Custody Suites**



# **Times Arrived in Custody**



### Times authorised into custody



### Time lapsed from arrival to detention authorised

- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 23 minutes.
- The highest waiting time was 1 hour and 11 minutes.
- The fastest time for a detained person (DP) to have their detention authorised was 2 minutes.

#### **Total Time in Detention**

- The average time a detainee was held in custody was 16 hours and 49 minutes.
- The longest time a DP was held in custody was 20 hours and 22 minutes.
- In contrast, the shortest time a DP was held in custody was 1 hour 20 minutes.

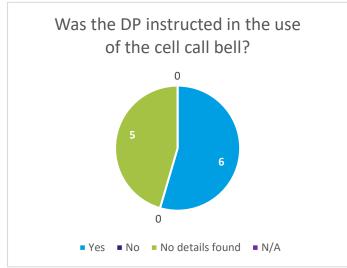
# **Provisions in Custody**

• All DPs were asked about their dietary requirements and allergies.

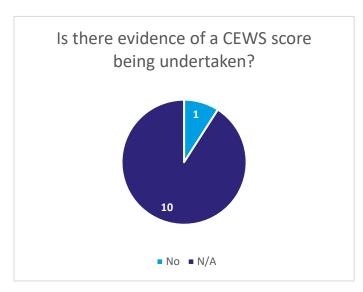






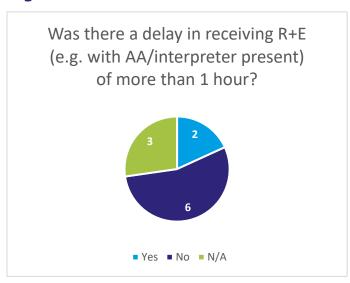


# **Custody Early Warning Score (CEWS)**



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

# **Rights Entitlements**

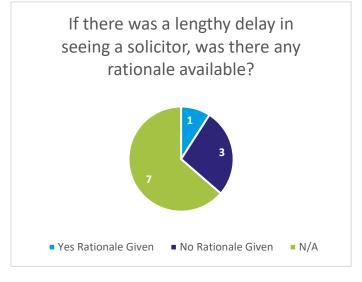


• All DPs were given their rights either at booking in stage or at a later stage during their detention.



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

- The average time for a detainee took to request a solicitor was 2 hours 25 minutes.
- In 4 of the 11 of the cases, the DP made the request for a solicitor within 34 minutes.
- The longest period for a DP to request a solicitor was 7 hours and 30 minutes.



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

- The average time taken was 1 hour 14 minutes for police to contact an onduty solicitor.
- The longest period of time was 1 hours and 10 minutes.
- The shortest was 6 minutes.



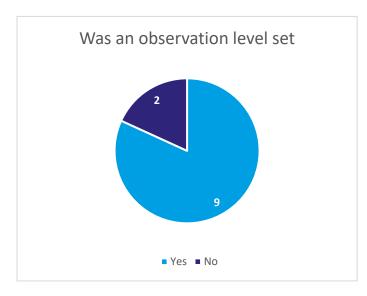
# The length of time taken for solicitor to arrive from the point of being contacted

- The Panel noted on three occasions there was no record between the DP requesting and solicitor arriving.
- The Panel also noted that on two occasions there were mitigating circumstances for the delay:
- 1) The solicitor advised custody that the DP was not known by their law firm, which required custody staff to speak to the DP again once she had sobered due to the level of her intoxication check information.
- 2) A call back had been scheduled once the DP had their blood sample taken.

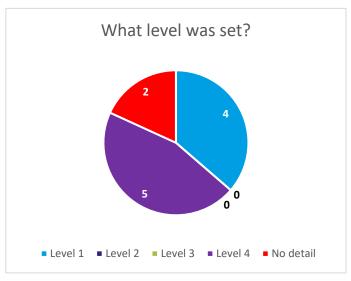
# The Panel made the following comments in relation to access to solicitors:

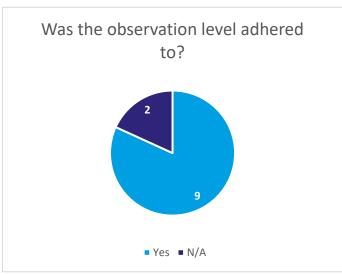
- In four of the records, Panel members commented on the difficulties they had in ascertaining record of solicitors attending. In one custody record, it was only known that a solicitor was present due to the interview notes.
- In a separate record, the Panel member noted that contact was made with the solicitor in good time and appropriate action was taken as per DP requests.

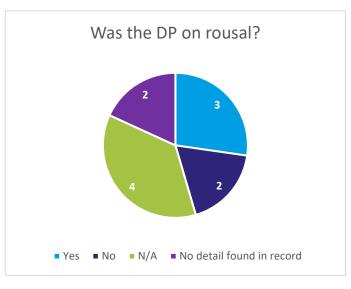
#### **Observation level**

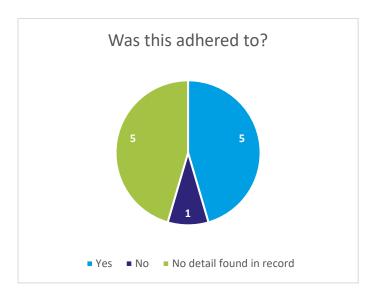


- The risk level is judged on 4 levels.
- Level 1 General (at least once every hour)
- Level 2 Intermittent (every 30 minutes)
- Level 3 Constant (constant observation CCTV and accessible at all times)
- Level 4 Close Proximity (physically supervised in close proximity).
- The Panel recorded 82% confirmation that all DP's risks were taken into account with two records being considered not applicable on the basis of the time the DP was held in custody.
- A number of the Panel members noted that the observation levels were maintained at a good level.

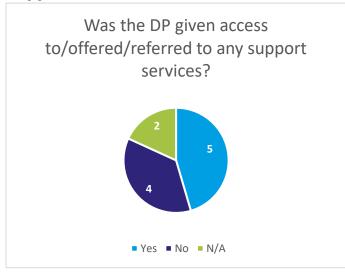








# **Support Services**

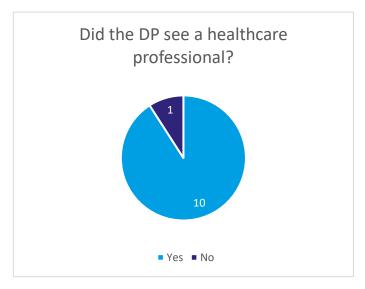


- 46% of DPs were offered support services in comparison to 36% who were not.
- 7 of the 11 custody records scrutinised suggested that there was no evidence to suggest that contact was made with support or Mental Health services during the detainees' detainment.

# **Healthcare Professional (HCP)**

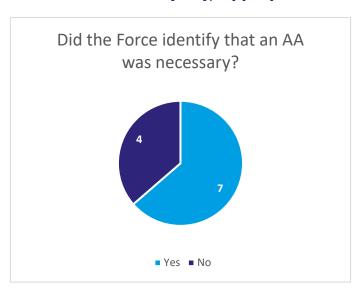
# **Healthcare professional (HCP)**

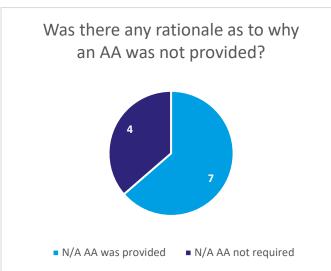
• Of the 11 cases reviewed, 10 were required to see a HCP and there were no delays in DPs receiving a health assessment. The Panel member noted that there was no rationale provided for the delay.





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





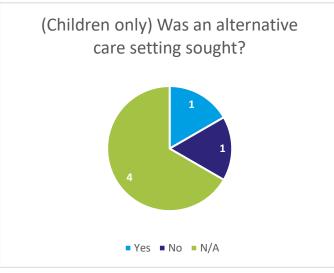


- The Panel advised that all 6 juvenile DPs considered that an AA was necessary and they were all contacted accordingly.
- The average time for a detention officer to make contact with AA was 1 hour and 1 minutes, and the average time the DP first made contact with an AA was 1 hour and 26 minutes.
- A Panel member noted that in one custody record, they were unable to ascertain when an AA had arrived at custody; however, did note that the DP was on Level 4 observation and de-escalated to Level 1 once the AA had arrived.

# **Children in Custody**

Within this section, this only focussed on the 6 juvenile female detainees as referenced in the <u>demographic</u> section above.





- None of the juvenile DPs were kept overnight.
- In the single record whereby alternative accommodation was sought, the Panel member noted that there was no detail of the address within the record; however, assumed it was the residence belonging to the AA.
- In all of the 6 records pertaining to children, none of them had reachable moments recorded.



