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Custody Independent Scrutiny Panel: Use of Force

June 23rd 2025

Police and Crime Commissioner for Dyfed-Powys
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Contents

Overview, Background, Purpose and Methodology

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

The CISP will be looking at topics from the previous year on a cyclical basis with the purpose of comparing and assessing whether learning identified has been implemented within custody services.

In June 2024, the CISP focussed on Use of Force (UoF). In preparation of this scrutiny activity, the Panel were reminded of the *Summary of Findings* from last year's report:

- In all cases scrutinised by the Panel, an observation level was set and all observation levels were adhered to.
- A number of the Panel members noted that the observation levels were downgraded from higher risk level grading to Level 1 appropriately during the DPs detention and that they were regularly monitored.
- The average time lapsed from the point a detainee arrived at custody and was authorised for detention was 23 minutes with the highest waiting time was 1 hour.
- The average time a detainee was held in custody was 19 hours and 8 minutes.
- All detainees were given their rights either at the booking in stage or at some stage during their detainment.
- Of the 16 cases reviewed, 8 required to see a HCP and there were no delays in DPs receiving a health assessment
- A rationale was provided for every Special Risk Clothing administered to detainees.

- Of those DPs subjected to a strip search, the Panel noted that a good rationale was provided.
- Those DPs requiring an Appropriate Adult all had a rationale provided.

In relation to areas of improvement detailed within the same report, the Panel specified:

- Of the five female detainee records reviewed under UoF, three were assigned a same sex officer and one record specified that the Panel member could not find information if the female DP was asked if they would like to speak to someone from the same sex.
- Gaps in information of detainee's rights (cell call bell, religious items, toilet pixelated).
- The average length of time taken for police to contact a solicitor was 55 minutes and the longest period being 4 hours and 7 minutes.

UoF remains a key aspect of policing and His Majesty's Inspectorate of Constabularies and Fire Service (HMICFRS) have provided feedback to Forces emphasising the need for good governance and oversight; ensuring that all incidents are managed well and that any UoF applied requires a justified rationale. The purpose of the scrutiny was to ensure that any UoF applied to any detainee was lawful and proportionate.

The Panel were provided with additional questions to consider included:

- Was force used in custody?
- What force was used?
- Was the force considered necessary and proportionate?
- Whether the rationale provided was sufficient?
- Were there any injuries to the Detained Person (DP)?
- Were there any injuries to custody staff as a result?

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:

Use of Force:
Overall, the Panel deemed that 54% of the records reviewed were compliant, indicating that no further action was from the Force due to the quality of the record. 42% were considered to be amber, due to lack of detail or clarity within the record. 6% were considered to be 'red' either due to disproportionate UoF (record 1) or lack lacking sufficient detail to make a determination (8 records).

Females:
Of the 8 Female DPs, it was noted that all of them were assigned a female officer and all female DPs were asked if they would like to speak with someone from the same sex. The Panel also noted that all females were offered hygiene facilities during their detention.

Observational Level:
All Observational levels set by custody were adhered to. Custody staff were deemed to manage risk and escalated/de-escalated appropriately adapting to challenging DP behaviour.

Decision to remove Anti-Harm Suites/Special Risk Clothing:
In May 2025, Dyfed-Powys Police (DPP) decided to eradicate Anti-Harm Suites (AHS) from the Force. There are instances within the CISP findings where the use of the AHS were used prior to May 2025, and were considered inappropriate by the Force, validating the decision for their removal.

Support Services:
20 of the 26 DPs were offered or referred to support services; and the 6 remaining, declined the option. Primary services offered to DPs were for mental health.

Healthcare Professional (HCP):
20 of the 26 saw a HCP with 6 experiencing delays. The Panel overall provided positive observations commending the custody staff for their caring, professional approach to the DP and also using their initiative to explore history of mental health to assess capacity whilst exploring Appropriate Adult opportunities via the HCP.

Children in Custody (CIC) Childrens Checklist:
There was one record which involved a CIC; however, the Panel were unable to view the Childrens Checklist. This will be rectified for future meetings. The Force have confirmed that the Children's Checklist was included in this record and there was evidence that custody staff are cognisant of the AWARE model (AWARE stands for appearance, words, activity, relationships and environment), and all these aspects help to build a fuller picture of the child's circumstances and potential causal factors in their offending. The Force are looking to engage a commissioned service to support with obtaining reachable moments, voice of the child, build rapport with the child and assist with care plans and outside referrals from custody. Further information on this can be found in the *Panel Observations* section.

Time Lapsed from Arrival to Detention Authorised:
The Panel noted that the average time from the point of a detainee arrived at custody to authorisation for detention was 31 minutes, with the highest waiting time being 1 hour and 42 minutes. However, due to the nature of violence displayed from the DP, this was deemed to be justified as per referenced in the *Panel Observations* section. The Force are also establishing a 6-month performance report comparing waiting times between each custody suites to identify suites who have consistently higher waiting times.

Areas for improvement:

Use of Force entries:
Content of the UoF needs to be efficiently replicated on the custody record. UoF forms are being completed by officers which are attached to the Occurrence log but not enough detail is specified in the custody record. The Panel has assisted in influencing feedback to custody staff regarding *"a dedicated detention log entry…that UoF in custody has taken place, what UoF was used, the reason/s UoF was needed, officer/s involved, and the outcome".*

Necessity for an arrest:
Two of the three custody records specified one necessity for an arrest, where the Force have confirmed that others could have been selected in addition.

Gaps in recording details on custody record:
Examples of hygiene facilities when declined not being recorded, religion not being routinely asked, food refreshments not being offered on occasions, and further examples of solicitor arriving or transfers not routinely being recorded on custody records.

Panel Observations

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

Theme	Observation	Force Response
Use of Force	1) Use of Force appears to have been used prior to DP taken to custody as they were handcuffed. Can you verify if there was any UoF whilst in custody towards the DP? 2) On four occasions, Panel members specified that there was insufficient detail in the log to evidence what force was used and rationale for use of force. Can this be verified? 3) *A Panel member specifically noted the following: "This is a 14 year old who tried to walk out of the cell after his grandmother. I'm not sure that it needed several officers taking him to the floor and handcuffing him to*	1) *I have reviewed the Custody record and identified Care plans at the beginning of the record that evidence the Use of Force in custody and the reasons for this. The detainee has attended the Custody unit violent and aggressive; he has been carried into the unit by arresting officers and taken directly to a cell. Cell procedure has been used. He has remained on Level 2 observations for 2 hours before being dropped to Level 1's to allow a period of rest.* 2) *From reviewing all four custody records, I have located entries in the Care Plan advising of the Force used and rationale. Please see details found below:* • *The first Custody record I have located entries in the Care plan that state the detainee was aggressive on arrival and had to be taken directly to the cell. A further detention entry under detention authorised*

	stop him from doing so, and it is clear from the record that his grandmother considered this to be excessive use of force." Do you consider the force applied to the DP was proportionate? 4) Shorts were forcibly removed due to the buckles possibly being used for self-harm. It was noted that the DP was placed on Level 3 observation; however, the Panel member questioned whether this was necessary to cut the shorts to preserve the DP's dignity. Are you able to provide some context to this decision?	*states "DP was strip searched, spit hood was utilised, take down techniques, cell procedure and ground pins used due to behaviour".* • *The second custody record contains information within the first care plan which states that the DP was brought into custody intoxicated and violent. The DP had already assaulted one officer by kicking and was then kicking out at the holding cell door and making verbal threats. Due to this, the custody officer requested that 3 female officers take the DP straight to the cell. DP remained resistant and so cell procedure completed to remove corded clothing and jewellery. DP left in own vest top and own trousers. Custody jumper also provided as own hooded top removed.* • *The third custody record contains information within the first care plan which states that the DP was booked into custody and being abusive. DP attempted to tie clothes around their throat, headbutt the toilet and flood the cell. Cell procedure used and DP moved from original cell and into dry cell to prevent further flooding.* • *The fourth custody record also contains information regarding UoF in the first care plan. It states that the DP has bitten an officer and has been kicking out at officers. This continued in custody when the DP tried to bite an officer when in the cell. Whilst trying to initiate the initial custody search, the DP has become non-compliant, kicked out at officers, resulting in the DP being*

		taken to the cell. DP trousers replaced with custody trousers as her own were wet. *3) I have reviewed the custody record and there is one detention log entry which I believe the panel member is referring to. It states that the DP returned to custody and wanted to sit in the cell with the DP, so this has been facilitated. Less than a minute later, the DP has hit the cell door and started shouting at his grandmother, so custody officer has gone to the cell to check on her. The DP has then proceeded to be verbally abuse both to the custody officer and their grandmother, so the grandmother has started to leave the cell. The DP has then tried to leave the cell and has been restrained by the custody officer and DEO (Detention Escort Officer). An affray alarm was activated, and further officers attended to assist with restraining the DP. The grandmother has become protective of the DP and so has been ejected from custody. Whilst this may seem from basic review to be excessive, given the age of the DP, it must also be considered that within the reason for arrest that the DP had already assaulted the arresting officer who had to deploy PAVA (Incapacitant spray) and it also highlights the DP's previous offences of assaulting emergency workers. The first care plan also states that the DP was very aggressive on arrival at custody and had to remain in handcuffs until going to the cell. The custody officer informed the DP that the plan was to interview him very soon, but that they needed to calm down and appeared to do so. However, following the arrival of his grandmother, the DP's behaviour escalated quickly and so I believe it was the correct decision*

		to remove her from custody and DP's father come into custody as AA. Without viewing the CCTV footage for this incident, which is no longer available, I would suggest that given the violence already displayed by the DP by assaulting officers and punching the cell wall, the force was necessary to prevent any further assault or injury. Whilst the DP's age must be considered, the number of officers required to safely restrain him again evidences the level of aggression, and not intervening would likely have resulted in further assaults on officers or the DP injuring himself by punching the wall again. *4) From reviewing the custody record, the DP has arrived intoxicated, become violent and uncooperative during risk assessment, and had to be taken to the cell. The DP had warning markers for self-harm and concealing items. The care plan states that "DP HAS HAD SHORTS REMOVED DUE TO BUCKLES POSING RISK TO DP AND OTHERS". I agree with this decision given the DP's intoxicated state and previous episodes of self-harm as the buckles could have been used to cause injury to herself or custody staff. L3 observations would have been selected, instead of L4, due to the aggression/violence from the DP. L4 observations would have increased the risk of an assault on custody staff or assisting officers.* *Although the custody records highlighted by the panel members in these observations do contain information relating to UoF, there is still some learning and improvement that can be taken from them. All custody records document the UoF on the care plan, which is relevant, and UoF forms are completed by all officers involved on their Mobile Data Terminal's (MDT)'s. These*

		UoF forms completed by the officers are attached to the occurrence and not the custody record on Niche. Internal discussions within Custody Services have resulted in communication being sent to all custody staff that the content of the UoF forms needs to be more efficiently replicated on the custody record. Whilst this information does not need to be as in depth as the UoF forms, a dedicated detention log entry can be submitted documenting that UoF in custody has taken place, what UoF was used, the reason/s UoF was needed, officer/s involved, and the outcome.
Specific Custody Record Concern Involving UoF	Within this custody record, the DP was held in custody for 2 days 10 hours and 55 minutes. It was noted that the DP, who was violent upon entering the custody, was carried to the cell. The Risk Assessment advises that the UoF was not carried out by detention staff. It is also unclear whether the DP had been seen by a HCP. Can you clarify: 1) What was the justification for the DP to be detained beyond the 24-hour PACE clock? 2) Did the DP see the HCP? 3) Had the UoF forms been completed adequately by all staff involved in the restraining of the DP?	*1) The DP was charged and remanded, with 4.5hrs still remaining on their initial 24hr PACE clock, for domestic related stalking and criminal damage. This charging decision was made following CPS (Crown Prosecution Service) direct advice. The DP was also wanted on warrant and so would have remained in custody to appear at the next available court in any case, even if the charging decision from CPS was either no further action or bail. The time of charge and remand was 17:43hrs on a Saturday evening and so the next available court would not have been until the Monday morning. Hence the 2d 10h 55mi detention period.* *2) Yes, the DP was seen on 2 separate occasions by HCP for fitness to detain and fitness to interview, and secondly for medication to be administered.* *3) Cell procedure was not conducted by custody staff and was conducted by arresting/conveying officer. UoF forms are not linked with the custody record, do not appear on the custody record, and so would not have been available for review by the panel member. However, I can reassure that UoF*

		forms were completed by all officers involved and these were attached to the occurrence. *As highlighted above in previous observations, improvements can be made to how use of force is documented on custody records and guidance has been sent to all custody staff on recording use of force in custody on a dedicated detention log entry.*
Strip Search	1) One Panel member noted that there was no clear rationale for the Strip Search to have been conducted. 2) Another Panel member noted an absence of a rationale for two other custody records in relation to Strip Search. Can both points be reviewed and clarified whether the application of a Strip Search was justified?	*1) C24084703 – No strip search was conducted. DP was intoxicated and violent, cell procedure conducted, and corded clothing removed which only consisted of a hooded jumper. DP remained in all other clothing including own vest top and own trousers. DP also provided with custody jumper for warmth. This is all captured on the first care plan.* *2) C25008679 – No strip search was conducted. Care Plan simply states that DP started to resist when being searched and kept placing his hands in his pockets. DP had to be restrained, taken to the cell, and cell procedure took place. C24089036 – No strip search was conducted. DP abusive towards staff on arrival at custody, taken to the cell, and cell procedure conducted.* *Upon review of both points, and the three custody records, it would appear that panel members are mistaking cell procedure for strip searches. Whilst a strip search can, on occasion form part of a cell procedure if required, they are two separate actions. No strip search was conducted in any of the three mentioned custody records.* *These observations are still of benefit as they have highlighted a learning opportunity for the panel members on the difference between cell procedure and*

		strip search. This information can be fed back to panel members during training, or the next panel meeting, to enhance their knowledge.
Time Lapsed from Arrival to Detention Authorised	1) The highest waiting time was 1 hours and 42 minutes with the Panel member noting that the circumstances were due to custody being busy and other DPs being booked in. Can you advise if this was justified? 2) From reviewing the times that DPs arrived at custody, there is a considerable increase of UoF custody records from the period of 18:00 onwards. Given that the Panel have identified that the primary service offered to DPs was for mental health, do you believe there is a link between this with regards to services becoming unavailable beyond office hours or would you assess other factors such as drugs or alcohol to be the main contributing factor?	*1) As highlighted, the custody record states that there was a delay caused due to custody being busy and other DP's being booked in. I can confirm that another DP arrived in custody 28 minutes before this DP and was still being booked into custody which would have caused an initial delay as there is only 1 custody officer on duty at this custody suite at one time. Within the first care plan on the custody record, it states that the DP arrived at custody intoxicated, agitated, and shouting at staff. Furthermore, it states that the DP became non-compliant during the search and DP was required to be taken to the floor with handcuffs and leg restraints utilised. Due to the level of aggression, the DP had to be taken straight to the cell and cell procedure completed. This would have caused a further delay with the custody officer having to oversee the cell procedure and then, once complete, the custody officer would only then be able to return to complete the admin tasks for authorising detention and care plan. Taking all the above into account, the delay of 1 hour 42 minutes is justified.* *2) This is a challenging question and one that I cannot give a definitive answer without reviewing each custody record in depth, which unfortunately would take a significant amount of time. However, despite mental health service provision being difficult outside of office hours, we still have access to HCP to conduct an initial assessment, and then request a full Mental Health Assessment*

		(MHA) if deemed necessary (these are not a regular occurrence). I would argue, from experience, that alcohol and/or drug consumption tends to be more of a causal factor in detainee violence than mental health. *For awareness of panel members, I am starting to compile a 6-month performance report for DPP Custody. One of the areas that will be assessed is waiting times (time between arrival at custody and time detention authorised). This data will be broken down per month, and per custody suite, and this will allow waiting times in each custody suite to be compared. This will highlight any issues that need to be addressed such as one suite consistently having longer waiting times in comparison to other suites.*
Necessity for an arrest	There were three records solely specifying the arrest necessity was *to conduct prompt and effective investigation;* the others had an additional necessity. Those three were in detention for 21 hours 55 minutes, 15 hours and 11 hours respectively. From reviewing the records, can you reassure whether the necessity for the arrest, justified each DP's detention?	*Custody record 1 – Custody record checked and no issue with necessity for arrest specified; however, due to the DP was arrested for assaulting their nephew they could have also considered "further necessity to protect vulnerable person", and "to prevent injury to self or another".* *Custody record 2 – DP arrested for fail to provide specimen for analysis (drink drive related). Necessity to conduct prompt and effective investigation is correct so that evidential specimen of breath could be obtained promptly at custody.* *Custody record 3 – DP arrested following allegation from partner that DP attempted to stab them in two separate areas of the body and suffered superficial wounds. Custody record records necessity as prompt and effective investigation and to prevent person causing physical injury.* *These observations have highlighted that, on two of the custody records, only one necessity was selected by the*

		custody officer when others were also relevant and could have been selected as well. Whilst this is not a regular occurrence across the Force, feedback will be provided to the custody officers involved on those two custody records. This will provide clarity and reassurance regarding the necessity for arrest during review and audits.
Food refreshments offered regularly	The Panel identified two instances where food and refreshments were not offered regularly. Was there a reason why this occurred in both records?	*Custody record 1- DP arrived intoxicated and aggressive at 1705hrs and remained on L3/L4 observations, with behaviour unpredictable, until asleep and placed on L2 rousing checks at 22:44hrs. DP did not wake until 08:46hrs, when they attempted to fill the cell with water. DP was processed, charged, and released at 10:11hrs. The first inspector review conducted at 23:43hrs documents that the DP is declining food and drink. Whilst the DP was clearly a difficult detainee to deal with and slept for 10 hours of their detention period, there are still no entries from the custody officer or DEO evidencing that food/drink was offered, provided, or declined by the DP.* *Custody record 2 – DP arrived at custody 21:07hrs and was provided with a cup of squash at 21:19hrs. DP then given hot chocolate at 22:48hrs. DP's behaviour became violent at 23:33hrs and so placed on L4 observations making it difficult to provide items in that time. DP asleep at 01:01hrs and moved into interview at 01:54hrs. DP then released following interview. Custody record shows DP was offered food/drink and provided with a drink twice within the first 2 hours of his detention. Following that time, and within the next 4 hours, DP became violent, was asleep, interviewed and released. I can identify no concerns regarding food/drink provision within this record.*

		These observations, particularly in relation to the first custody record, highlight that there may be under-recording of occasions where detainees are offered food/drink and these offers are declined by the detainee. It is important that these instances are recorded to evidence that custody staff are routinely offering detainees food/drink and that their welfare regarding this aspect is being considered. If this is not recorded on custody records, then the assumption will arise that custody staff are not providing food/drink to detainees. This will be monitored during monthly audits and feedback provided if this appears to be a wider issue.
Hygiene	The Panel noted that there were two instances whereby DPs were not offered showers or handwashing facilities. Can you verify if this is the case and if so, why does neither record show that hygiene facilities were not offered to DPs?	*Custody Record 1 – DP arrived at custody during the early hours of the morning under the influence of drink/drugs and so required a rest period for sobriety to return. Rights and entitlements were completed at 12:44hrs, when awake, and DP made aware that numerous things were available to them including washing/shower facilities. DP was processed, interviewed, and released 3 hours later.* *Custody Record 2 – DP arrived at custody intoxicated and slept overnight. DP woke at 11:18hrs the following morning and a detention log entry recorded at 11:24hrs that DP had been given a toothbrush to clean teeth prior to interview. DP interviewed, processed, and released less than two hours later.* *Whilst neither of these custody records raise concerns regarding hygiene provisions for the detainee involved, as with food/drink observations above, I believe it is important to record on the custody record when hygiene facilities are offered but declined by detainees. At present only when hygiene facilities are used by detainees will a transfer entry be recorded showing that*

		the detainee has been moved from the cell to the shower room. However, I can reassure panel members that all detainees are made aware that hygiene facilities and products are available to them during their detention. A list of all available provisions is provided to all detainees when they sign for their rights and entitlements.
Rights & Entitlement	A Panel member could not ascertain that the DP had been given their rights either at booking in or later in their detention. Can this be checked and confirmed?	*Custody record checked and I can confirm that DP arrived at custody at 18:17hrs, detention authorised at 18:56hrs, and rights and entitlements completed at 19:03hrs. DP wished for his mother to be informed of their arrest, declined legal advice, and declined a copy of the codes of practice.*
Legal Representation	1) The average time for custody to contact legal representation was 6 hours and 47 minutes. Given the focus of this CISP is on UoF; and therefore, delays are likely to occur to usual processes in ensuring DPs wellbeing, would you assess this average time to be proportionate? 2) The longest period of time for custody to contact a solicitor was 13 hours and 42 minutes. Within the same record, the Panel member could not find detail of the solicitor being present or arriving. Can you specify why there was a delay in this instance for custody to contact a solicitor on the DP's behalf and can you verify if there was an entry specifying the presence of a solicitor on behalf of the DP?	*1) Without going through each custody record, it is difficult to assess this average time for police to contact solicitor, as each custody record will be unique in circumstances. This would depend on numerous variables including time of arrival at custody, intoxicated or not, demeanour of the DP, fitness for interview, outstanding enquiries still to be completed, likely time for interview to take place, etc. For example, if a detainee is intoxicated then rights and entitlements cannot be completed and signed for by the detainee until sober. This will then cause a delay in contact being made with a solicitor.* *2) Custody record reviewed. DP arrived at custody at 19:16hrs 14/02/25 and solicitor was not requested 08:51hrs. However, rights and entitlements were also not completed until 08:49hrs. The DP arrived at custody heavily intoxicated and argumentative. Due to intoxication, rights and entitlements could not be completed with the DP until sober. The DP*

	3) The Panel noted on three occasions that there was either no record or it was difficult to ascertain details surrounding the contact of a solicitor arriving. Are you able to provide reassurance that solicitors did arrive on these five occasions?	*required a period of rest overnight to allow sobriety to return. Rights and entitlements were completed when awake the following morning and request for solicitor was completed 2 minutes after rights and entitlements completed. This would explain the delay in solicitor being contacted. However, I can locate no detention log entry regarding solicitor arriving or present in interview with DP. This is an oversight by the custody officer and feedback will be provided.* *3) Custody Record 1 – DP requested solicitor but was arrested for S5 public order offence. DP appears, upon review of custody record and occurrence to have been charged without interview. Therefore, solicitor would not have attended custody. This is possible when there is sufficient police evidence available via officer statements and body worn video footage to evidence that the demeanour and actions of the DP amounted to a S5 public order offence. This is not something that I would expect a Panel member to be aware of in fairness to them. However, there is no entry on the custody record to highlight this and no records relating to the DP speaking with a solicitor via telephone etc.* *Custody Record 2 – I can confirm that there are detention log entries at 12:49hrs stating that DP going into consultation with solicitor, and at 13:39hrs stating that consultation finished and going into interview. Solicitor and firm name recorded in both entries.* *Custody Record 3 - I can confirm that an entry recorded at 15:02hrs 19/02/25 naming the*

		solicitor and that solicitor receiving disclosure from the OIC. Further entries recorded highlighting consultation and solicitor going into interview with DP and officer. However, this record would have proven to be a little confusing for the panel member to review as the DP initially arrived in custody in February, when interview took place, and then returned on bail in April for the purposes of charge only and solicitor would not have been required to attend on this occasion. *What these observations do highlight is that, whilst the time of request for a solicitor is recorded on the rights and entitlements section of the custody record, the time of arrival of the solicitor is not being routinely recorded, and transfers are not being recorded on each occasion showing detainees being moved from the cell into the solicitor room for consultation with their solicitor. This area will be monitored during monthly audits and feedback will be provided force wide if identified as being a wider issue, or feedback provided to specific custody staff if a regular occurrence with individual members of staff.*
Observational Level	A Panel member could not find detail to advise if the DP was on rousal. Can this be clarified and specified if the DP was assessed on rousal?	*I can confirm that the DP was on rousing checks. The first care plan completed sets the observation level at L2 checks at 30 minutes intervals. DP remained on rousing checks from 20:09hrs to 23:53hrs, DP had been rousing well in that time, and decision made to drop to L1 checks 30 minutes intervals.* *I am happy to provide guidance to panel members regarding what each of the four observation levels entail during the next panel if deemed necessary.*
Special Risk Clothing/Anti-	1) Of the 5 records that specified wore AHS, there was no instance where	*Custody Record 1 (Oct-Dec 2024) – DP initially being monitored on L2 rousing checks due to intoxication.*

Harm Suite (AHS)	the clothing was removed by force. With the Force's stance on removing AHS in May 2025, can you specify whether the AHS applied to DPs in these instances were proportionate?	*However, seen to tie jumper around their neck. Officers have entered the cell and removed the jumper, the DP kicked out and spat at officers. DP continued to make threats to take their own life and had recent self-harm episodes. DP placed in AHS and observation level changed to L3 CCTV checks. As this use of AHS was pre-May 2025, AHS would still have been an option for the custody officer. L4 observations could have been considered, without AHS, but given the violence displayed (kicking/spitting) this would have posed a risk to officers. This consideration is not recorded on the custody log which I would have liked to have seen.* *Custody Record 2 (Oct-Dec 2024) – DP arrived at custody, abusive at the desk, refused to engage in risk assessment, and was taken to cell with cell procedure conducted. DP had made comments to arresting officers regarding harming himself and record states placed in AHS due to unknown risks and to prevent harm. Placed on L3 CCTV observations. This use of AHS was not appropriate. Other options should have been considered in the first instance to evidence good risk management, such as consideration of L4 observations (via door hatch if necessary), or L3 observations without AHS. These other, more proportionate options would likely have had the same effect given that the DP settled into custody well and went to sleep with no issue. DP was moved from L3 observations to L2 rousing checks due to intoxication, roused well and was then moved to L1 30 observations. This aspect evidences good risk management by the custody officer, but the initial use of AHS was not appropriate.* *Custody Record 3 (Oct-Dec 2024) – DP arrived at custody abusive and intoxicated. Due to this, DP was*

		taken to the cell and cell procedure completed. DP tied clothing around his neck and tried to headbutt the toilet. DP has then proceeded to flood the cell. DP moved to dry cell and monitored on L3 obs. This use of AHS was not appropriate and the use of AHS would not have prevented the DP from headbutting the toilet. Alternatively, DP could have been handcuffed again during cell procedure and monitored on L4 observations by officers until he calmed sufficiently. This would likely have had the desired effect given the DP had calmed and was using the custody phone to speak with his grandmother less than one hour later. In addition, the use of the dry cell was not appropriate as it was not for any forensic reason and the custody staff should have knowledge of how to isolate the water, via the cupboard, next to the cell door to prevent flooding. *Custody Record 4 (Jan-March 2025) – AHS was not used during this custody record. The DP arrived at custody rude, intoxicated, and risk assessment could not be completed. DP had urinated himself twice since his arrest and so he was provided with "custody clothing" as his own clothing had been soiled. It would appear that the panel member has mistaken "custody clothing" for AHS.* *These observations have highlighted that the decision made by the force, in line with national recommendations, to remove Anti-Harm suit from use in DPP was the correct decision. On each of the records, other, more suitable options were available other than anti-harm clothing, and using these other options would have evidenced better risk management by the custody officers involved.*

Appropriate Adult	Two Panel members asserted that two DPs had historically been given an AA, but on this occasion were not provided one. In one instance, the rationale for not providing one was not clear and in the other, the DP had refused. Can clarification be provided why there was no clear rationale for a DP not to receive an AA and can a DP refuse an AA if custody staff deem that a DP requires one? A Panel member noted a Fitness to Release (FTR) was deemed to be required by custody staff; however, after a sleeping review, it was then decided that this was not required. Can you provide some clarity on this?	*To answer the question if a DP can refuse an AA if custody staff deem that a DP requires one. In short, no. A vulnerable adult or child cannot refuse the presence of an AA. Police are legally obligated to provide an AA to safeguard their interests and ensure the understand their rights and the circumstances/situation. The DP can refuse to speak with the AA, but they cannot prevent the AA from being present during police interactions such as interview, rights and entitlements, processing, etc. For reassurance, a rationale was provided by the custody sergeant 11.26hrs as to why no AA was required.* *In addition, from reviewing the other custody record I can confirm that an AA was present and assisted the detainee during their detention.* *Regarding clarity around the final point for FTR. I have reviewed the custody record and a FTR was requested as planned and completed prior to DP's release from custody. This is captured in the HCP section of the custody record.*
Child in Custody	The only child record dip sampled shows that the Children's Checklist, Voice of the Child nor Reachable moments were recorded. Can this be validated and what assurances can you provide to show that custody in Dyfed-Powys are addressing this issue to ensure the wellbeing of children in custody?	*Children in custody checklist is present, along with the AWARE model for Voice Of the Child. Reachable moments have not been considered.* *This is an area which Custody Services are aware has been a routine issue across the Force and reachable moments and voice of the child are not being completed sufficiently. To rectify this, panel members will already be aware from ICV Panel Meetings, DPP are introducing the Reachable Moments Project into all DPP custody suites in the very near future. This service is being provided by Adferiad, who will have trained Reachable Moment Workers attend custody for every child. This*

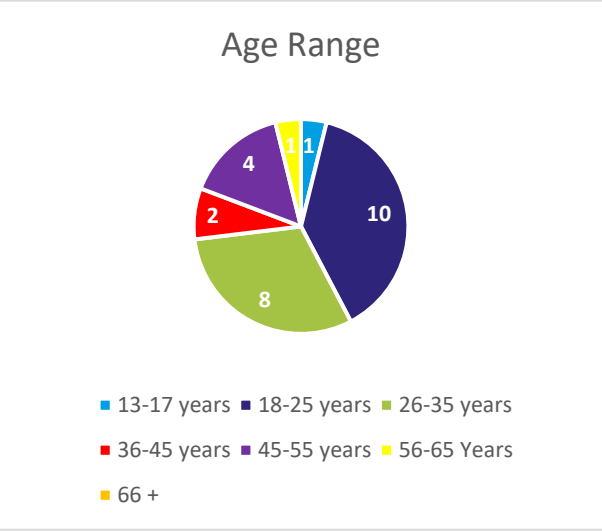
		will cover reachable moments, voice of the child, build rapport with the child, assist with the submission of suitable referrals into partner agencies, creation of a care plan with an outcome star specific to each child, and provide support both during and post custody with follow up checks after release.
Religion	The Panel could not ascertain details in 16 out of the 26 records reviewed that religion was asked of the DP. Given that this is classed as a protected characteristic within the Equality Act 2010, can you advise why custody staff are omitting this detail?	*Religion no longer forms part of the risk assessment question set since the introduction of Niche, this is unlikely to change and DPP have no autonomy over this. Religion is now captured in the "detainee name & info" section of the custody record. It is also not a mandatory field that needs to be completed and so this means that it can be missed on occasion.* *Having checked the custody records provided for this CISP, both easy-read version and the full custody record version, information about the DP's religion is not extracted from Niche on either of these record types. The easy-read only extracts name and DOB, and the full record extracts name, DOB, address, place of birth, height, weight, build, hair colour, eye colour, sex, officer defined ethnicity, and self-defined ethnicity. Neither extract religion from Niche as part of the report. This will inevitably make it difficult for the panel members to ascertain if religion has been covered.* *Having checked the 30 custody records provided for this CISP on Niche, religion was recorded on 22 of the records (17 x no religion, 3 x atheist, 2 x other Christian) and not recorded on 8 of the records. This evidences that, based on these records, staff are not omitting this detail and are capturing it on the majority of occasions (73%). However, it does evidence that there is still room for improvement in this area and this*

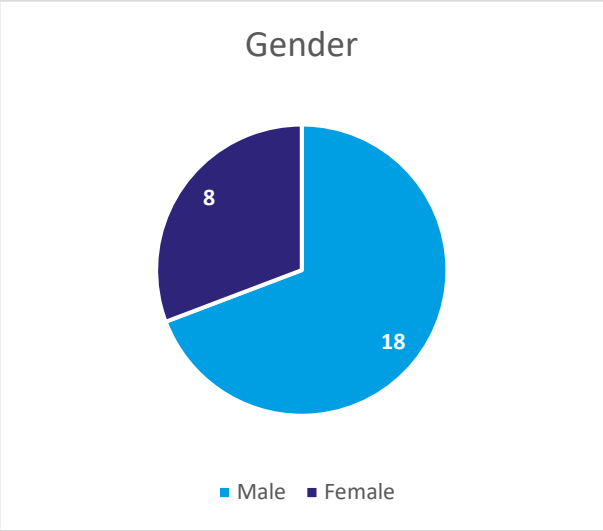
		will be monitored during monthly audits with guidance sent to custody staff as a reminder if deemed necessary.

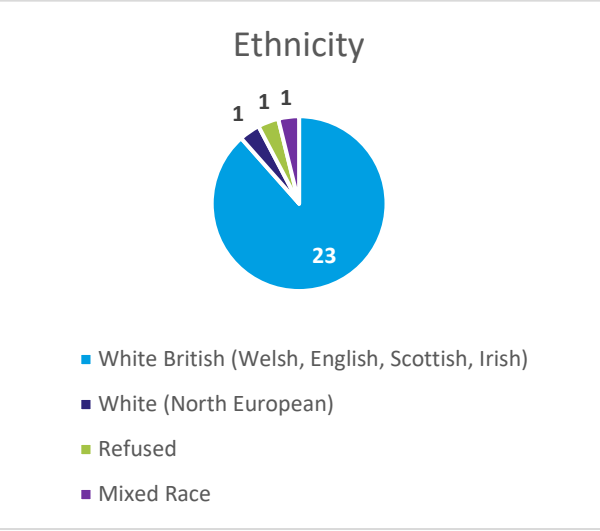
Annex- Custody Record Review Findings

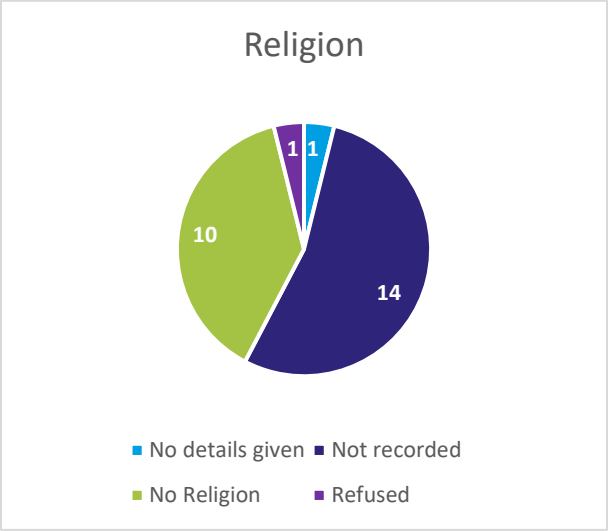
The data below outlines the results of the feedback forms completed by the Panel members which was analysed to identify the positive and areas requiring improvement in each specific area of custody with the focus of Use of Force in custody. This section of the report is supplemental to provide context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

Demographics



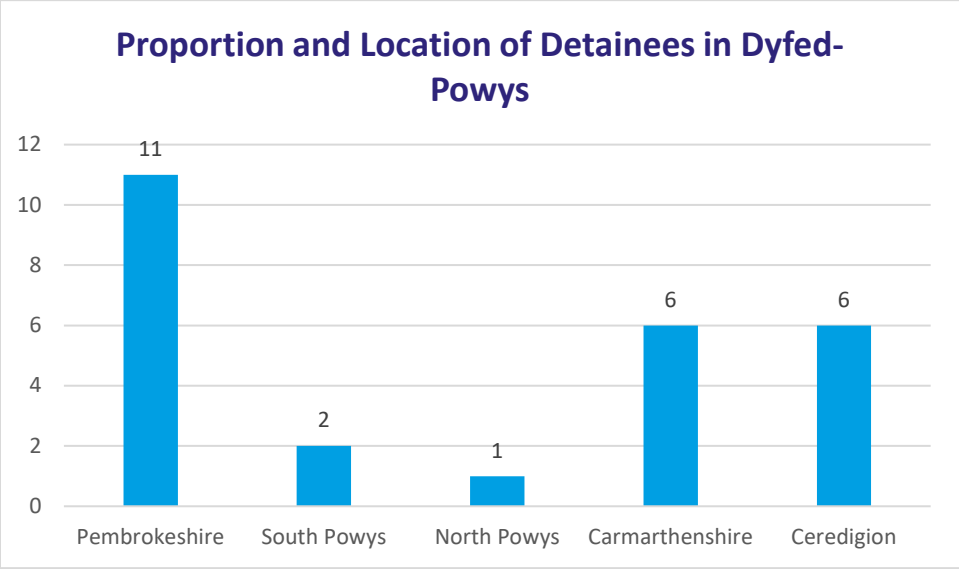




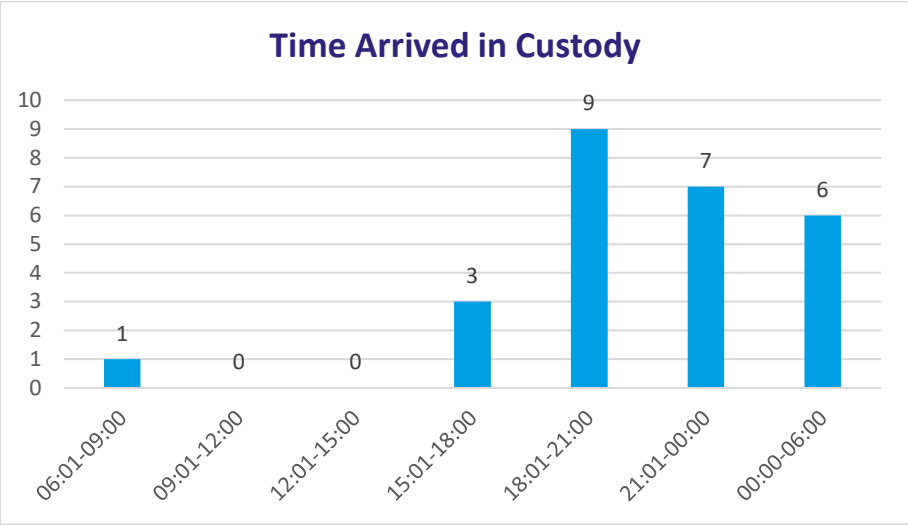


- The Panel could not ascertain details in 16 out of the 26 records reviewed that religion was asked of the DP.

Custody Suites

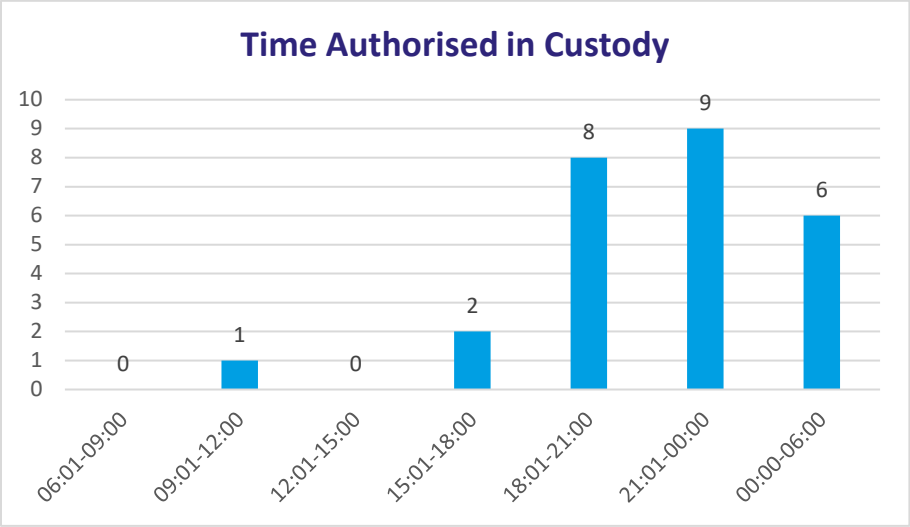


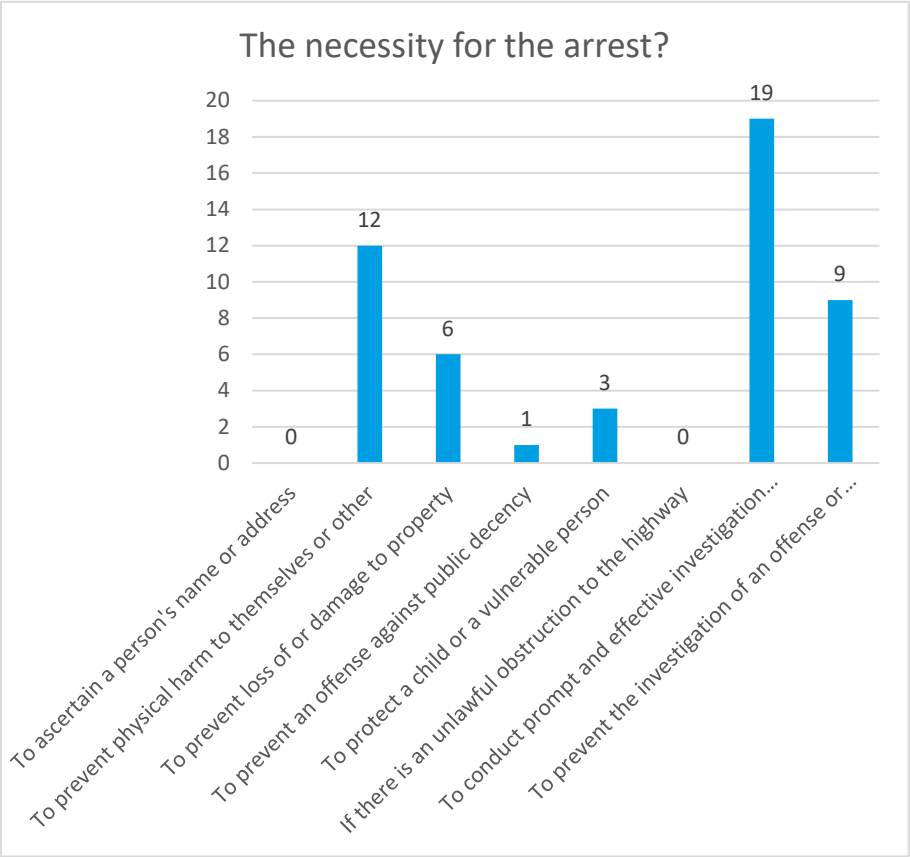
Time Arrived in Custody



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 31 minutes.
- The highest waiting time was 1 hours and 42 minutes with the Panel member noting that the circumstances were due to custody being busy and other DPs being booked in.
- The fastest time for a detained person (DP) to have their detention authorised was 4 minutes.



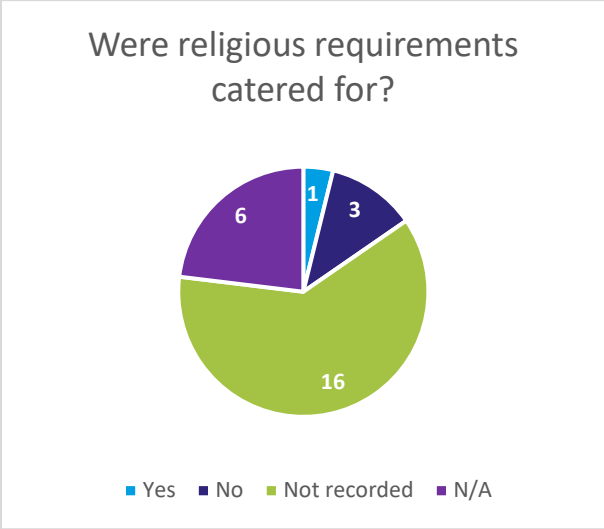


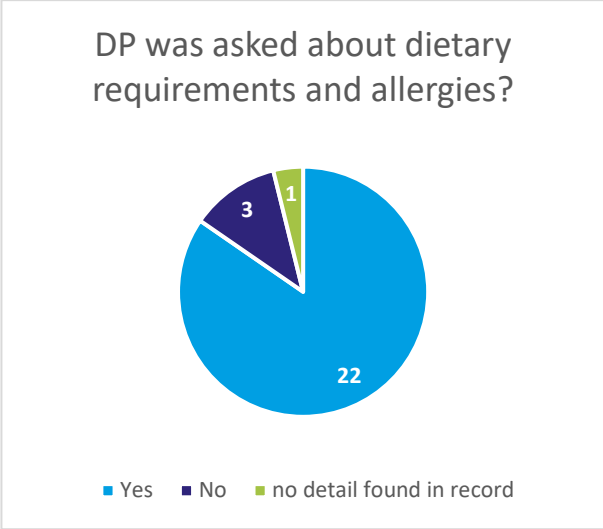
Total Time in Detention

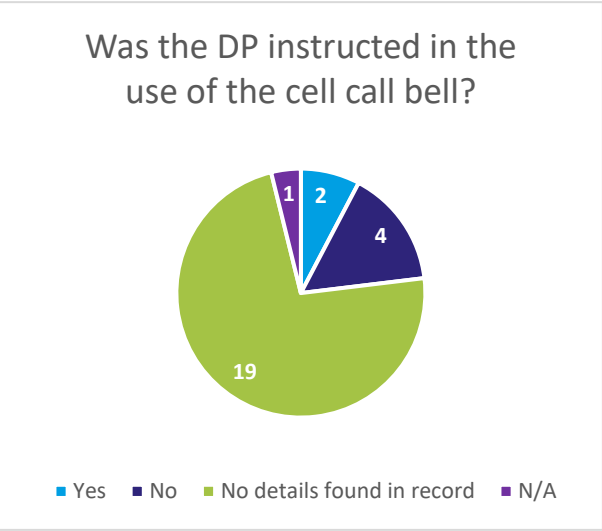
- The average time a detainee was held in custody was 19 hours and 39 minutes.
- The longest time a DP was held in custody was 2 days 10 hours and 55 minutes.
- In contrast, the shortest time a DP was held in custody was 3 hours and 15 minutes due to HCP advising that the DP was not fit for detention and taken to hospital.

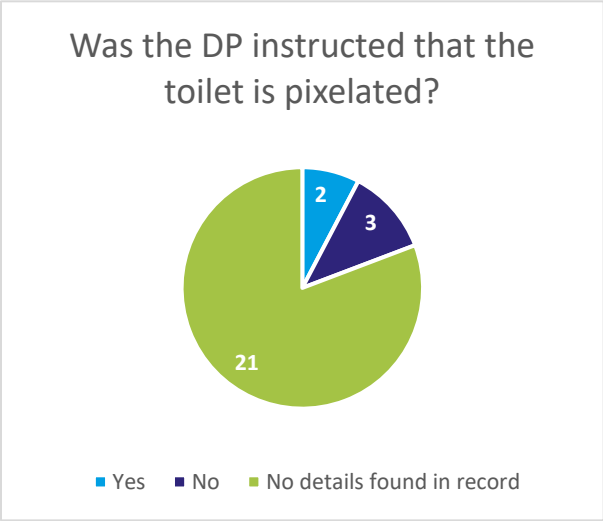
- The Panel were asked to ascertain the necessity for the arrest. The list of necessities under PACE are:
  - To ascertain a person's name or address
  - To prevent physical harm to themselves or other
  - To prevent loss of or damage to property
  - To prevent an offense against public decency
  - To 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 offense 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 physical harm to themselves or other*.
- Only three records solely specified the arrest necessity *to conduct prompt and effective investigation;* the others had an additional necessity. Those three were in detention for 21 hours 55 minutes, 15 hours and 11 hours.

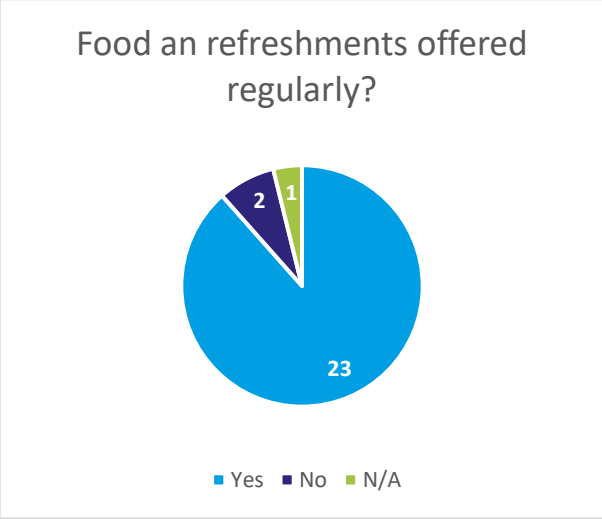
Provisions in Custody





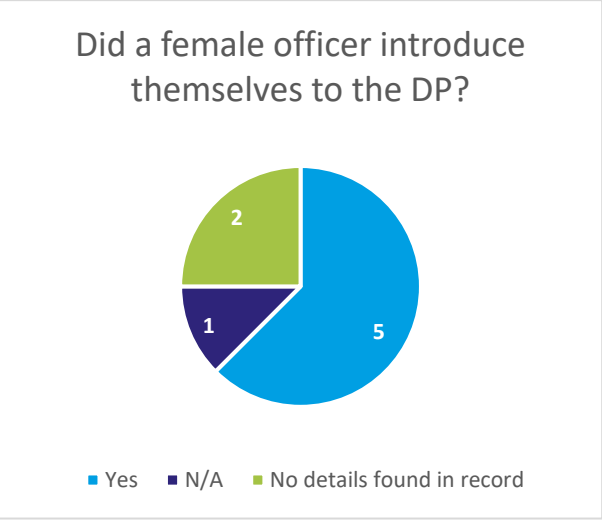




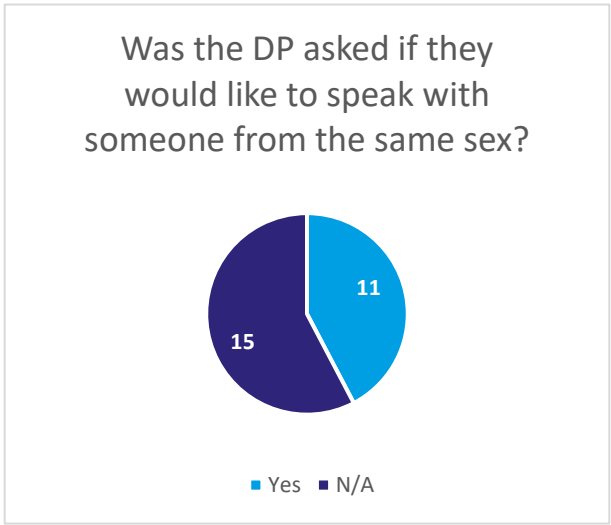


- The Panel specified that there were absences in the recording of religious needs, pixelation of the toilet and cell call button.
- In the instance of the Panel member recording as Not Applicable, this was due to a HCP assessment that deemed that the DP was not fit to detain and was taken to hospital early in their detainment.

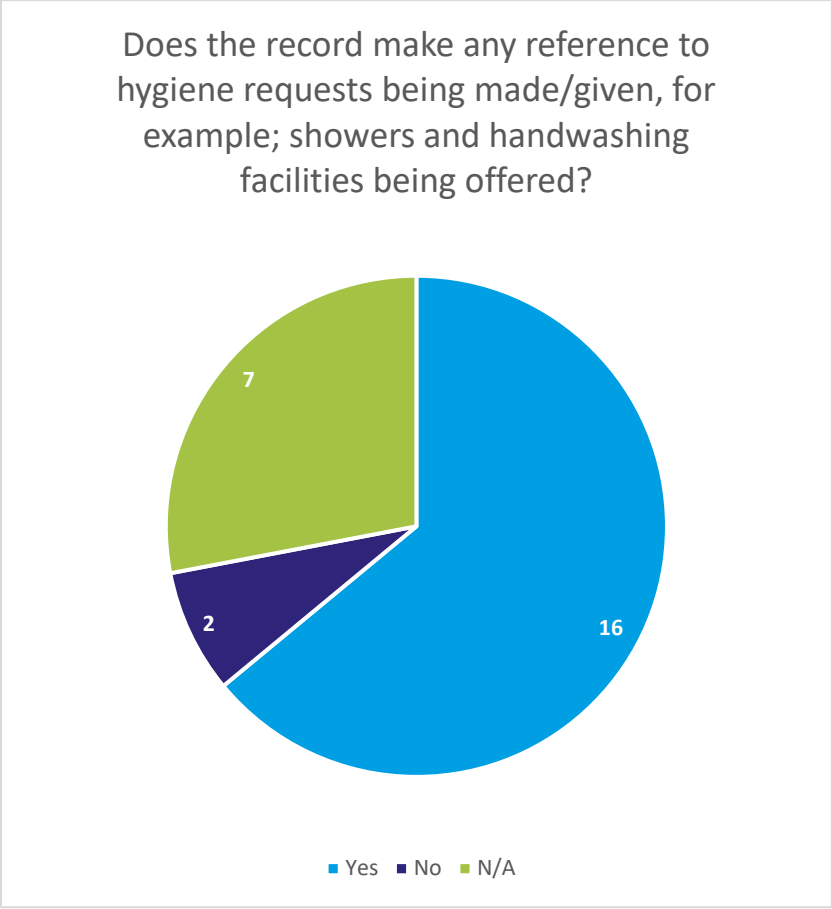
Female Detainees



- Of the 8 Female DPs, it was noted that all of them were assigned a female officer and all female DPs were asked if they would like to speak with someone from the same sex.
- One Panel member noted that the menstrual products were not applicable due to the DPs age.

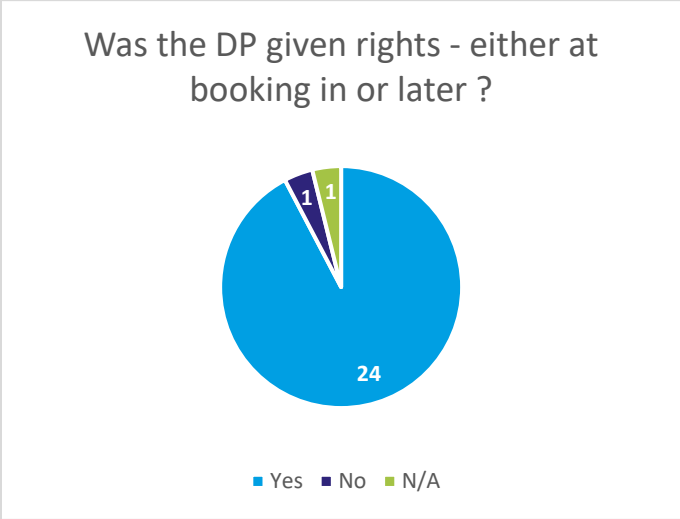


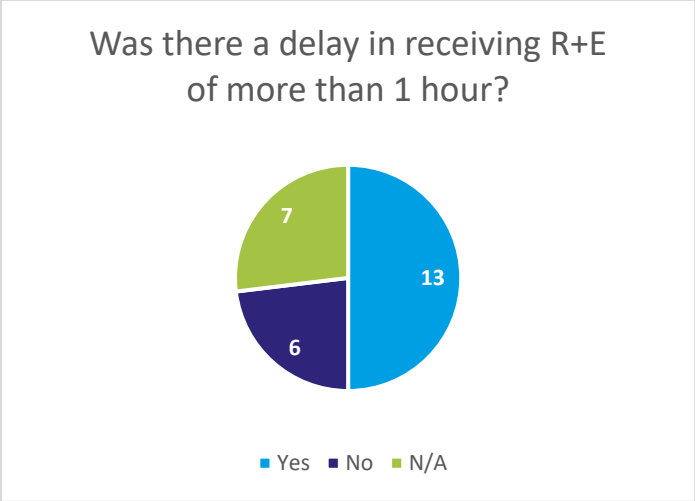
Hygiene



- It was noted that all 8 female DPs were offered hygiene facilities.
- Two records specified that this was not offered to DPs. This is clarified in the *Panel Observation* section.

Rights and Entitlements





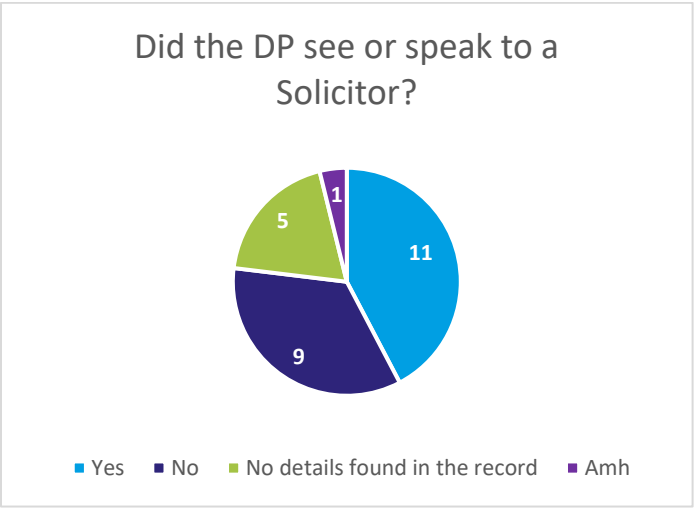
- The Panel member noted that one DP was deemed unfit for detention by the HCP; therefore, considered the question on receiving their rights to be not applicable.
- One Panel member could not ascertain that the DP had been given their rights either at booking in or later in their detention.

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

- The average time for a detainee took to request a solicitor was 8 hours 16 minutes.
- In 7 of the 26 of the records, the DP declined the option to request a solicitor.
- The longest period for a DP to request a solicitor was 24 hours and 30 minutes.

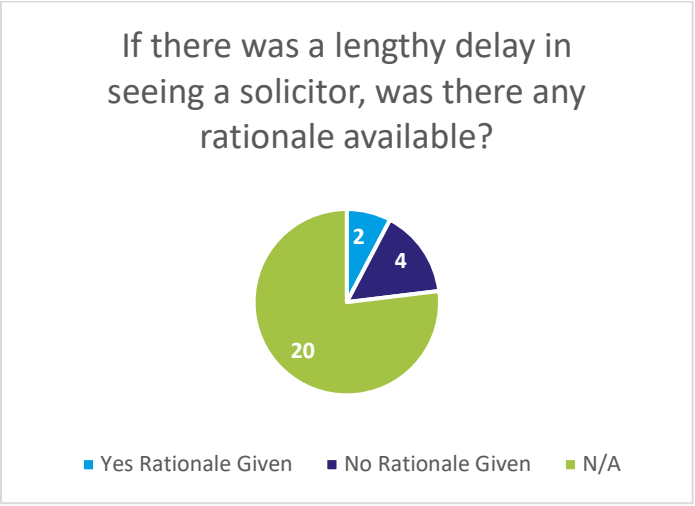
The length of time taken for police to contact a solicitor

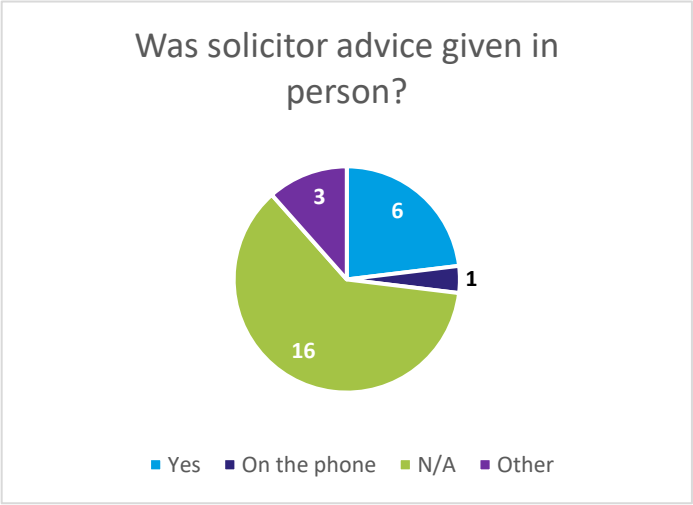
- The average time taken was 6 hours and 47 minutes for police to contact an on-duty solicitor.
- The longest period of time was 13 hours and 42 minutes.
- The shortest was 4 minutes.

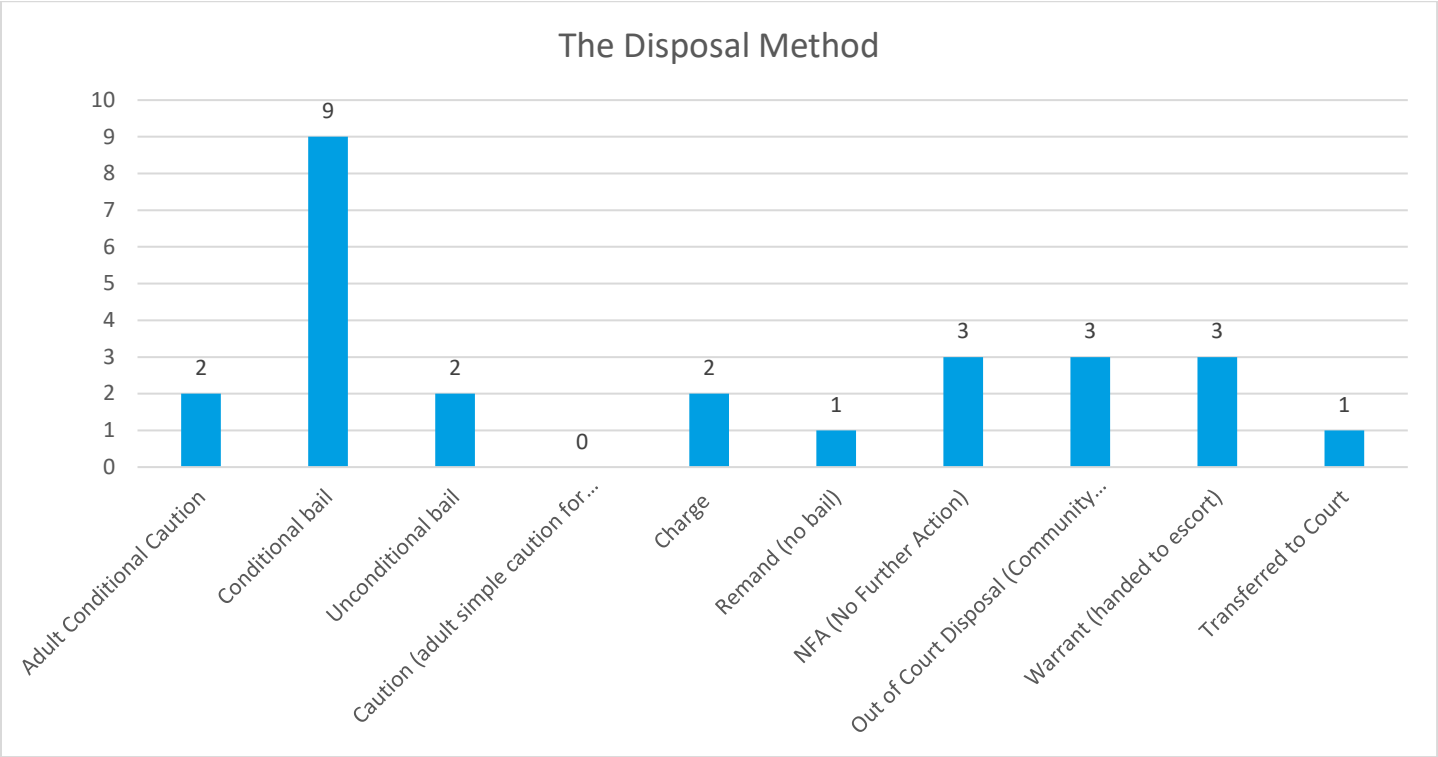


The length of time taken for solicitor to arrive from the point of being contacted

- The average time it took for a solicitor to arrive after being requested was 6 hours and 41 minutes.
- The Panel noted on three occasions that there was either no record or it was difficult to ascertain details surrounding the contact of a solicitor arriving.
- The Panel made the following observations on the delays in solicitor's seeing the DPs as recorded in the custody record:
    1) DP under the influence of alcohol and to have been provided their Rights & Entitlements.
    2) DP was taken to hospital.
    3) DP changed their mind and cancelled the solicitor.
    4) DP was taken to court and it was suspected that the solicitor would meet them there.

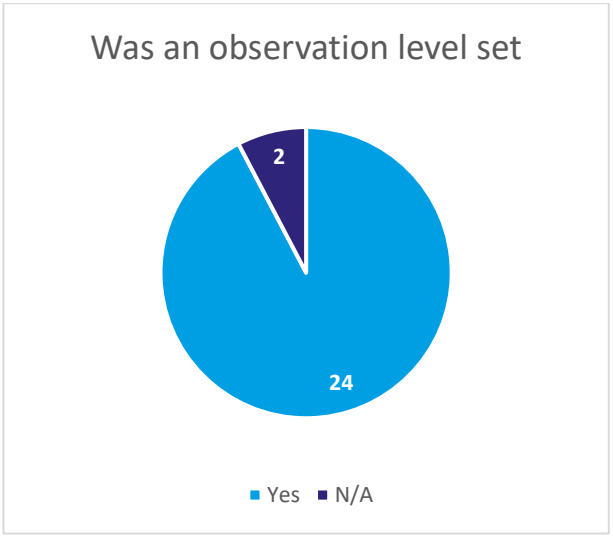


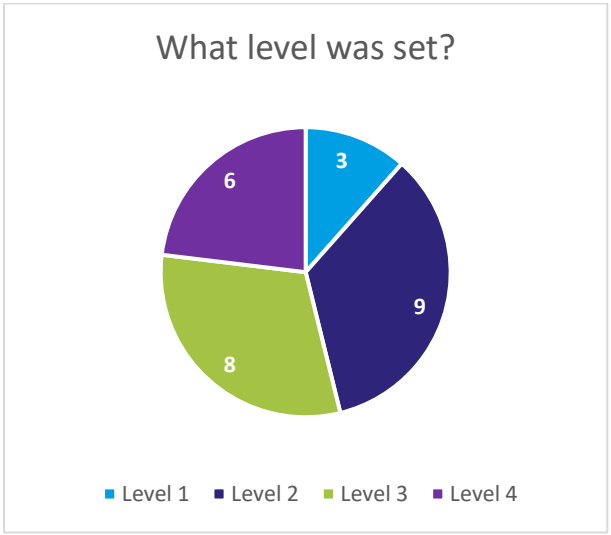




- The Panel were asked to note the disposal method to assess whether the DP's detainment was proportionate to the necessity of arrest.
- 35% of disposal methods was for conditional bail which is the process that allows officers to attach conditions to bail which may support victims and/or witnesses, preserve evidence and mitigate further crime.
- Of the three records with the disposal method being NFA, the arrest necessity specified for two of them was "*To conduct prompt and effective investigation of the offence*." However, this was also to *Prevent person causing loss or damage to property; Prevent person causing physical injury; and To prevent the person suffering physical injury.*

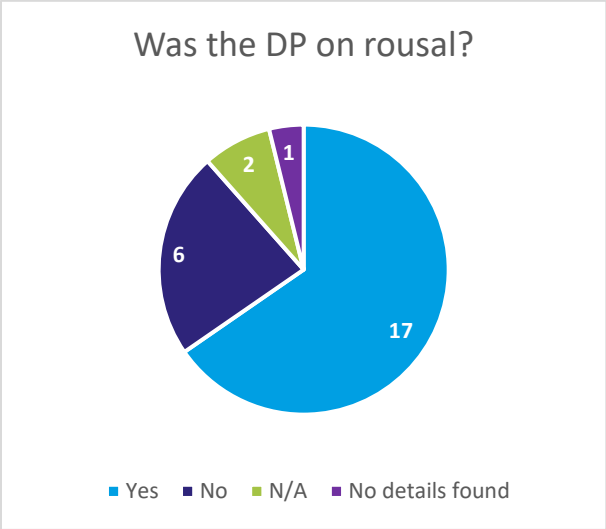
Observation Level

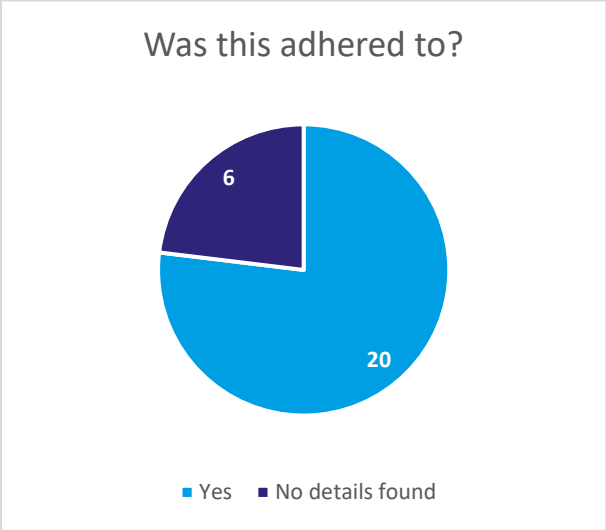




- The risk level is judged on 4 levels.
- Level 1 General (at least once every hour)
- Level 2 Intermittent (every 30 minutes)
- Level 3 Constant (constant observation CCTV and accessible at all times)
- Level 4 Close Proximity (physically supervised in close proximity).

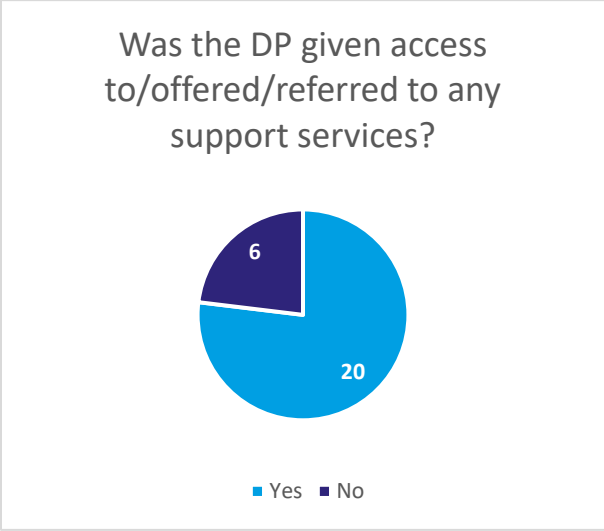
- The Panel recorded 92% confirmation that DPs risks were taken into account.
- Of the two records that were deemed Not Applicable (N/A) this was due to one DP being deemed not fit for detainment by the HCP and the other is believed to be entered in error, as the observation level in a later question was deemed to be adhered to by the same Panel member.





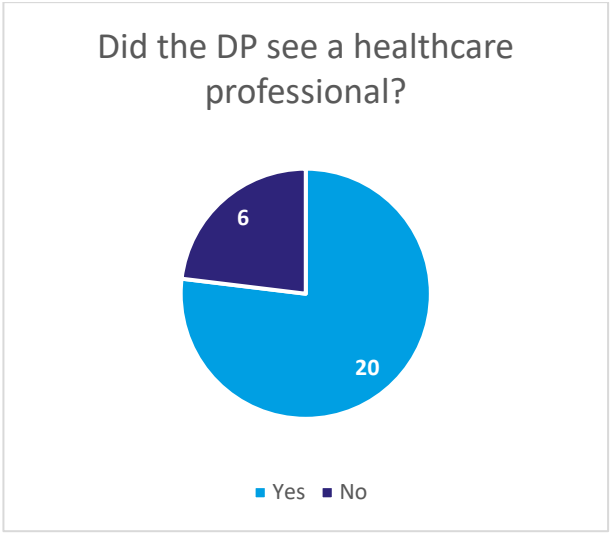
- All Observational levels set by custody were adhered to.
- A Panel member could not find detail to advise if the DP was on rousal.
- The Panel made the following comments in relation to the observational levels:
  1) *"Observation level effectively escalated from 2 to 3 and then reduced to 1. Custody staff responded to the situation accordingly."*
  2) *"Observation level was reviewed during the period in custody, and increased when there were clear concerns about suicidal ideation. The level was reviewed and reduced later during the period in custody."*
  3) *"Observation levels reduced from 4 to 1 during period in custody."*

Support Services



- Panel members specified that on 7 occasions the DP had declined the option of support services.
- Panel members stressed that the primary service offered to DPs was for mental health. On one other occasion, they were offered Social Services.

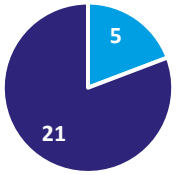
Healthcare Professional (HCP)



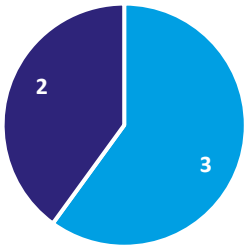
- The Panel noted the following observations in relation to HCP provision:
  1) Custody professional and caring referred to HCP appropriately.
  2) Custody staff identified that the DP had a history with MH and learning difficulties.
  3) Good practice that the record shows understanding that previously an AA was deemed necessary so appears to have given extra regard for the requirement on this occasion.
  4) Mental health concerns have been acknowledged whilst the DP was in custody and HCP assessments sought. AA was contacted and attended in time for interview.

Special Risk Clothing (SRC)/Anti-Rip Suites

Was the detainee given a safety suit/Special Risk Clothing (anti rip-suit) to wear?

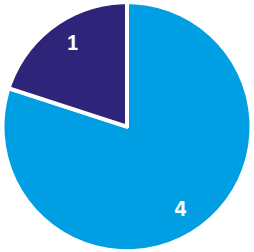


Did the detainee engage with the risk questions?

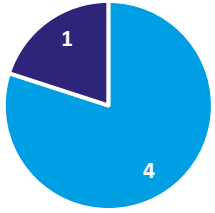


- All DPs that were allocated an Anti-Rip Suite, were assessed as at risk of self-harm.
- In no instance were the clothing removed by Force.

Where a suit was provided has a rationale been provided?

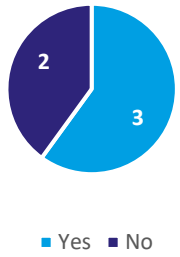


If clothing was removed, were there continuing risk assessments?

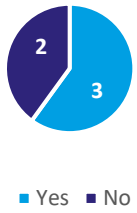


Does the record contain evidence of de-escalation, distraction items or other methods of reducing the detainees risk level?

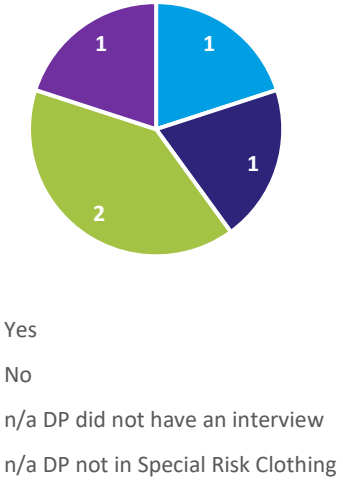
Does the record contain evidence of the Special Risk Clothing being discussed in staff handovers?



Does the record contain evidence of the Special Risk Clothing/Anti-Rip Suit being removed at the earliest opportunity?

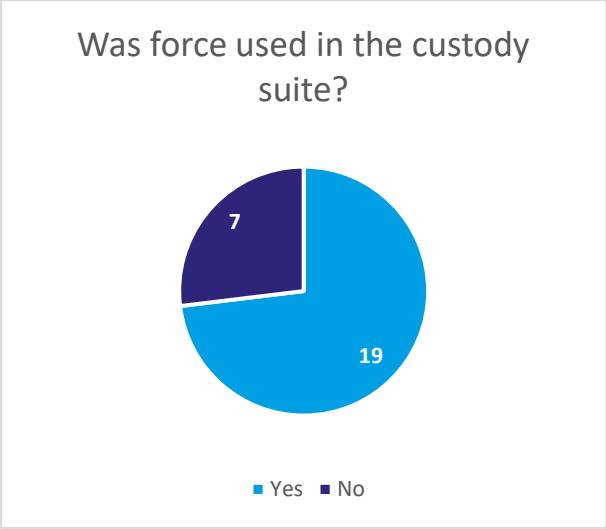


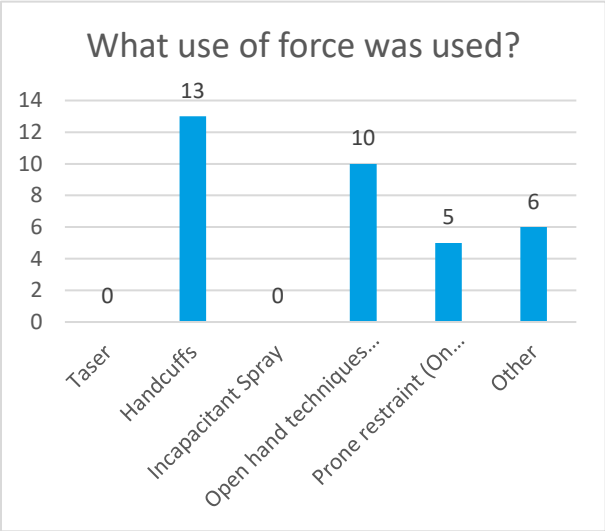
Does the record contain evidence of the Special Risk Clothing/Anti-Rip Suit being removed prior to interview?

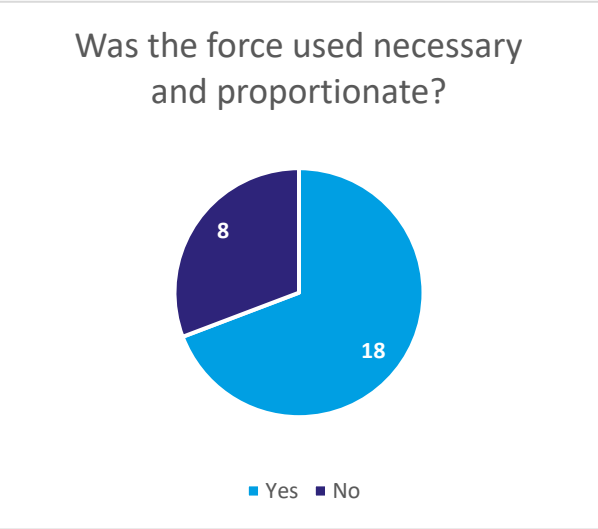


- The Panel specified the following in relation to the use of SRC:
  1) The DP was put in SRC due to the risk of self-harm, but no record of how this was communicated with the DP or whether this involved the use of force.
  2) The reason for giving DP wearing a SRC was due to DP making comments to officers whilst in transit to the custody that they intended to kill themselves. DP refused to answer at custody desk and therefore the DP has been placed in an anti-harm suit due to the unknown risks to prevent further harm".
  3) Clothing was removed as DP had urinated themselves on two occasions twice.

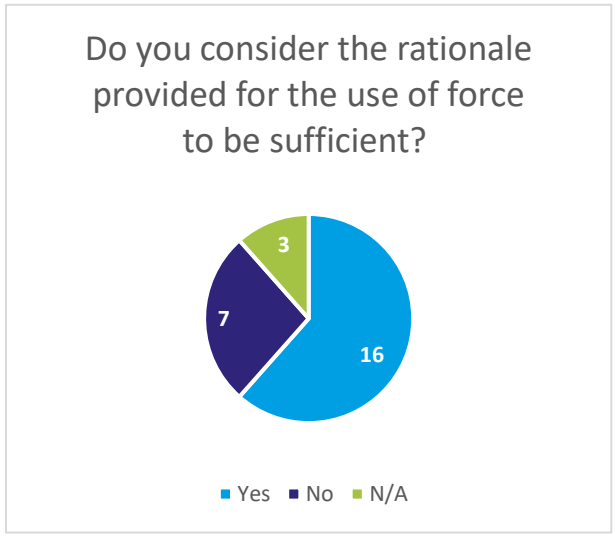
Use of Force

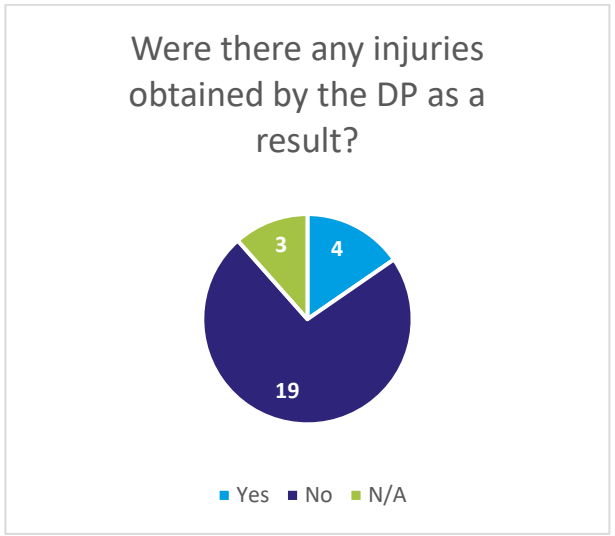


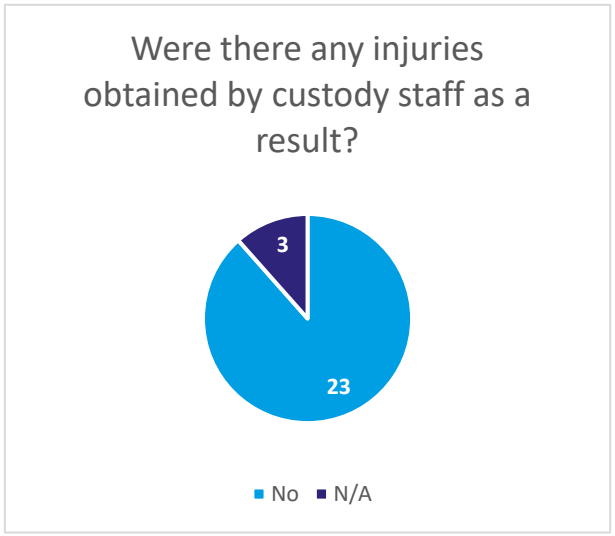




- The Panel members that deemed that the force used was not proportionate, specified the following reasoning:
  1) Use of Force appears to have been used prior to DP taken to custody as they were handcuffed.
  2) On three occasions, Panel members specified that there was insufficient detail in the log to evidence what force was used and rationale for use of force.
  3) *"This is a 14 year old who tried to walk out of the cell after his grandmother. I'm not sure that it needed several officers taking him to the floor and handcuffing him to stop him from doing so, and it is clear from the record that his grandmother considered this to be excessive use of force."*
  4) Shorts were forcibly removed due to the buckles possibly being used for self-harm. It was noted that the DP was placed on Level 3 observation; however, the Panel member questioned whether this was necessary to cut the shorts to preserve the DP's dignity.

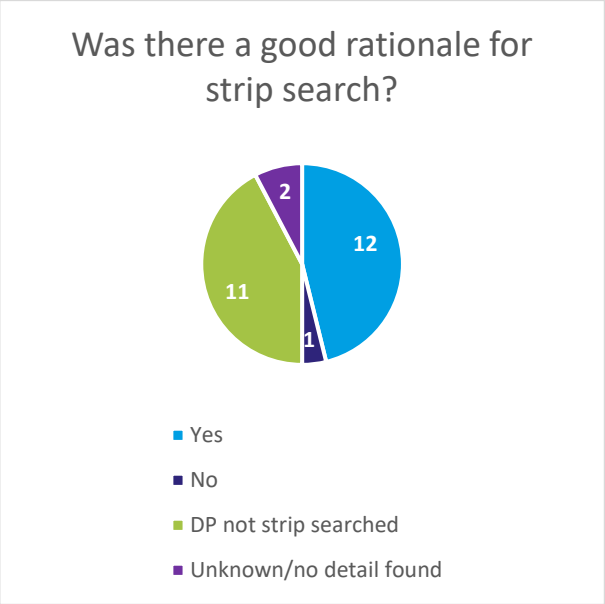


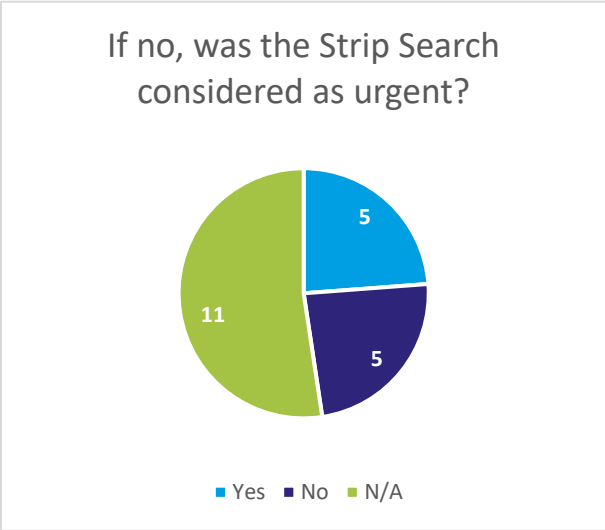




- The Panel had the following comments in relation to UoF:
  1) The DP was aggressive upon arrest and taken straight to their cell. The cell procedure was conducted but unable to locate on the record. It appears that after closing the cell door the DP continued to kick and slap cell door.
  2) Record contains note 'DP WANTED NOTING OF HER BRUISES IN INNER ARMS AND KNEES' but no explanation or exploration of whether this was in relation to UoF.
  3) Use of force was proportionate and necessary.
  4) DP was extremely violent, banging their head in the van and also on CCTV shows aggression in cell, punching walls/door spitting over the cell and shouting verbal abuse at staff.

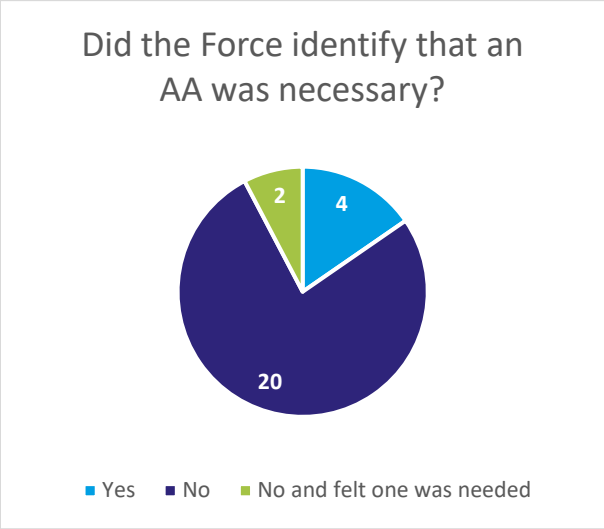
Strip Search





- One record was identified to have an Appropriate Adult (AA) present during a Strip Search.
- One Panel noted that there was not a good rationale for a strip search to have been conducted specifying that their was no clear rationale for the Strip Search to have been conducted.
- Two other Panel members noted an absence of a rationale for a Strip Search.

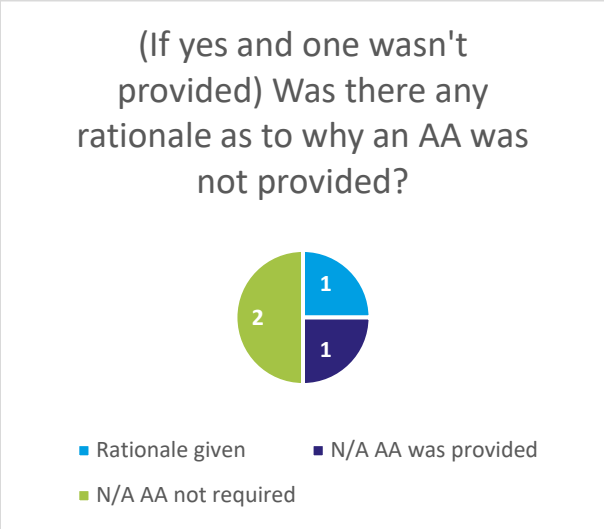
Mental Health (MH), Appropriate Adults (AA) & other Vulnerabilities



The Panel noted the following reasons why certain detainees were considered vulnerable:

- 4 instances of suicidal ideation.
- Medical concerns for blood pressure.
- Child under the age of 17.
- 4 instances of references of Mental Health including depression and anxiety.

Two Panel members asserted that two DPs had historically been given an AA, but on this occasion were not provided one. In one instance, the rationale for not providing one was not clear and in the other, the DP had refused one.



Children in Custody

There was one child DPs in the dip sampling of UoF. That one child did not:

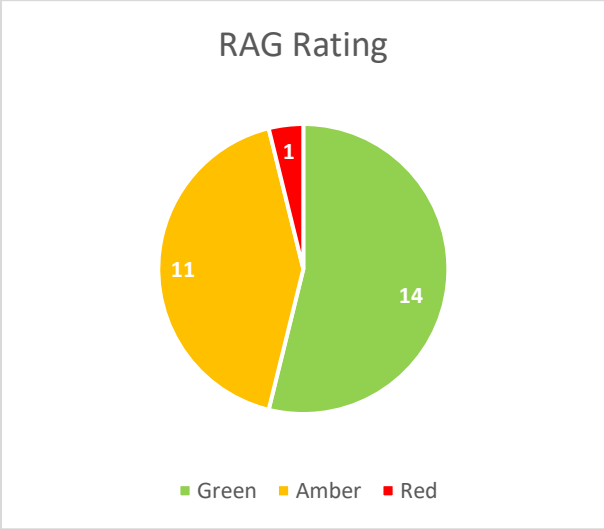
- Receive a charge during their detainment.
- They were detained for a total of 5 hours and 39 minutes and were not kept overnight.
- Social Services were contacted.
- The Children's Checklist was not completed, nor was the Voice of the Child or Reachable moments.

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
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.	**No further action required at this point.**
All Rights & Entitlements have been provided to the detainee.	
Clear de-escalation, distraction items etc. used to mitigate risk of detainee DSH.	
Little or unclear justification for the use of the Anti-Harm Suit, use of force or strip search.	**Advice/further training given to custody staff.**
Insufficient information to determine any delays in the detainee receiving their rights for legal representation or an appropriate adult.	
Inconsistent recording of Rights & Entitlements.	
No rationale or justification is not proportionate.	
Decisions made in the absence of risk information and with no other rationale.	

Significant delays in detainees seeing HCP, legal services or an appropriate adult. **No apparent consideration for detainee's vulnerabilities.**	**Further exploration required in relation to lack of rationale. Cases to be raised with custody inspector.**



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 rationale the Panel provided for their grading:

Green	Amber	Red
*"Rationale**s** detailed, care plan maintained, food/drink provided as requested."*	*"No real concerns about the custody experience and DP appeared to have needs met. The custody record however is bland and lacking details to be able to see proactive care on level 2 and then down grading to one. Stating very aggressive in capitals but no evidence in custody. It's the lacking details doesn't help to give a full picture. Unclear statement that chords cut out of clothing*	*"DP violent - carried to cell - Risk assessment states U of Force form to be completed and report states (last page - no use of force used by detention staff). Unclear whether HCP seen DP."*

	but custody clothing given. Perhaps more details would help"	
"I believe the force were very proactive in this difficult arrest, and did everything possible to care for the DP."	*"Given TOSH (Thoughts of Self Harm), unclear why AA (Appropriate Adult) not deemed appropriate - explanation on the form would have provided assurance fully considered"*	
"DP well cared for and good practice shown."	*"No clarification identified Use of Force whilst in custody - DP was aggressive on arrest spitting at officers and taken to cell immediately - recorded as no use of force whilst in custody."*	
"Use of force was appropriate. DP deemed not fit for detention and transferred to hospital."	*"Very little information on log to evidence rationale for use of force or what techniques were used."*	