HMICFRS
His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Care Quality Commission

Report on an inspection visit to police custody suites in South Wales Police

by HM Inspectorate of Constabulary and Fire & Rescue Services and Care Quality Commission

19–30 June 2023

Contents

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Note: Data supplied by the force.

Force

South Wales Police

Chief constable

Mr Jeremy Vaughan

Police and crime commissioner

Mr Alun Michael

Geographical area

South Wales

Date of last police custody inspection

April 2016

Custody suites

- Cardiff: 59 cells
- Swansea: 24 cells
- Merthyr Tydfil: 41 cells
- Bridgend: 41 cells

Total cell capacity: 165

Annual custody throughput

In the calendar year 2022, 21,904 detainees entered custody.

Custody staffing

- 1 superintendent
- 1 chief inspector
- 7 inspectors
- 63 custody sergeants
- 88 custody detention officers
- 3 police constables dealing with bail.

Health service provider

Mitie

Summary

This report describes our findings following an inspection of South Wales Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and the Care Quality Commission (CQC) in June 2023. It is part of our programme of inspections covering every police custody suite in England and Wales.

The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to detaining people safely and respectfully, with a particular focus on children and vulnerable adults.

To help the force improve, we have made four recommendations to it and its police and crime commissioner. These address our main causes of concern.

We have also highlighted a further 15 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and working with partners

South Wales Police has clear governance arrangements for the provision of custody. There are strategic and operational meetings to oversee custody services, and we found senior leaders taking an active interest in custody. However, despite these arrangements, the oversight isn't robust enough. There has been limited improvement since our last inspection. It is a cause of concern.

The force manages its custody services across four custody suites at Cardiff, Swansea, Bridgend and Merthyr Tydfil. We saw personnel stretched at busy times, which sometimes led to long waits for detainees to be booked into custody. They weren't always able to carry out all the duties expected of them, such as providing showers or exercise for detainees.

The force generally follows PACE and its codes of practice though this isn't always followed when carrying out reviews of detention. It has adopted the College of Policing's authorised professional practice (APP) guidance for custody but again it doesn't always follow this. And not all of the personnel we spoke to had good knowledge of the guidance content.

The force collects and monitors information to show how well custody services perform, for example, the number of detainees entering custody and average detention lengths. But some important information isn't collected, such as how long detainees wait for a mental health act assessment, and some information

isn't accurate. This makes it difficult to assess outcomes for detainees, and it isn't clear how senior managers use performance information to improve custody services.

The governance and oversight of the use of force in custody isn't good enough. The data on use of force incidents in custody doesn't support effective scrutiny because it isn't accurate and isn't always properly recorded. There is no routine quality assurance of incidents and the force doesn't view them on CCTV. Our CCTV review found incidents weren't always managed well. The force can't assure itself or the public that when force or restraint is used in custody it is necessary, justified and proportionate. This hasn't improved since our last inspection. It is a cause of concern.

The quality of recording on custody records also isn't good enough. There are few quality assurance arrangements to review custody records and assess how well services are provided at the different stages of a detainee's journey through custody.

The force understands its responsibilities under the public sector equality duty, and has a strong strategic focus on equality, diversity and inclusion. It monitors disproportionality data for some aspects of custody, for example, strip searching of children, and discusses this at strategic and other senior management meetings. The force is also open to external scrutiny from others. It responded positively to our inspection findings, quickly starting work to improve the service provided to detainees in custody.

The force works with agencies such as the youth justice service to support children and address the causes of offending behaviour. There are some good diversion schemes to support both children and vulnerable adults. However, joint work to help people with mental health conditions who come to police attention or are arrested is more limited. Outcomes for these people are poor.

Pre-custody – first point of contact

Frontline officers have a good understanding of what makes a person vulnerable and take account of this when deciding whether to make an arrest. They generally receive good information from the force's call handlers to help them deal with incidents. Officers try to avoid arresting children, where possible, by exploring alternative ways of dealing with the incident.

Support for frontline officers dealing with people with mental health conditions isn't always good enough. It is sometimes difficult for them to get advice from mental health professionals. At times this leaves them making decisions about whether to detain someone under section 136 of the Mental Health Act 1983 on limited mental health advice. When people are detained under section 136, officers have long waits with them at hospitals or mental health facilities.

In the custody suite – booking-in, individual needs and legal rights

Custody personnel are patient and reassuring and treat detainees with respect. Detainees are usually offered the opportunity to speak to a member of custody personnel in private when they are booked in. Privacy for detainees is generally well maintained, though they aren't always told about the CCTV operating in the suites and in cells.

Custody personnel understand how to meet the individual and diverse needs of detainees and try to do so. The custody suites have various facilities to help those with hearing or visual impairments and people with physical disabilities. But custody officers don't routinely ask detainees if they have caring responsibilities, and more could be done to meet the needs of women.

The force is thorough in identifying risks when detainees enter custody, and generally manages these well. Observation levels are mostly set at the correct level and the checks are usually carried out well and at the right time, including for intoxicated detainees who require rousing.

However, as in our previous inspection, most custody officers continue to routinely remove any corded clothing and footwear from detainees, rather than deciding this on an individual risk assessment. And anti-rip clothing continues to be used as a way of managing risk without always having good enough justification for its use. Handovers between shifts aren't carried out with all custody personnel to make sure risk information is fully shared. These practices don't follow APP guidance.

Custody officers usually authorise detention appropriately based on information provided by arresting officers. They give clear explanations of rights and entitlements to detainees, and in a way that considers their individual needs. But easy read versions of the rights and entitlements aren't consistently given to those who might need them, and there aren't enough copies of the PACE code C booklet to give to detainees.

Some detainees spend longer than necessary in custody because their cases aren't always dealt with promptly enough. Reviews of detention are poor, often don't comply with the requirements of PACE code C and aren't conducted in the best interests of the detainee. This is a cause of concern.

In the custody cell – safeguarding and healthcare

The general cleanliness across the four suites is good. However, there are potential ligature points in the communal showers and exercise yards in all the suites and in the cells at Cardiff and Swansea.

The approach to detainee care is reasonable. Custody personnel show a caring attitude towards detainees, and most detainees we spoke to felt that they had received good care in custody. However, detainees aren't always informed of the care provisions available to them so may not know what they are entitled to. Food and drink are regularly provided but few detainees are offered showers or exercise or given distraction materials.

There are suitable arrangements to safeguard children and vulnerable adults in custody. Referrals are made to other agencies and there is an intervention scheme based in custody to support children and to try to prevent offending behaviour. However, girls aren't always assigned a female personnel member as they should be. Custody officers usually make early contact to secure an appropriate adult (AA) to attend at the earliest opportunity. Some AAs arrive promptly but some children and vulnerable adults wait a long time before receiving support.

Children are generally only detained when necessary, but some spend a long time in custody as their cases aren't always dealt with quickly. Care for children in custody is mixed and doesn't always take account of their specific needs. The lack of available alternative accommodation arranged through the local authority means most children charged and remanded remain in custody instead of being moved as they should be.

Healthcare practitioners (HCPs) offer a good standard of care to detainees. However, HCPs aren't fully embedded in the custody suites and have to travel between them. These contractual arrangements mean care isn't always consistent. Support for detainees with substance misuse needs is very good. Medicines are stored and administered appropriately.

The arrangements for referring detainees with suspected mental health conditions to mental health nurses aren't appropriate. Detainees are referred to the HCP, who decides whether to refer on to the mental health nurse. HCPs shouldn't make these decisions as they don't have the required knowledge, training and information. It means some detainees who need professional mental health help may not receive it, and this also leads to delays for those detainees who are referred. It is a cause of concern.

Release and transfer from custody

Custody officers generally make sure detainees are released safely. They carry out the pre-release risk assessment with the detainee present, discuss any risks with them and help them get home. However, the recording of this isn't always good enough. Custody detention officers complete digital person escort records (dPERs) well for detainees who are attending court or who have been recalled to prison, with appropriate oversight by custody officers.

When detainees are remanded, they are generally transferred promptly to the next available court. This keeps their time in custody to a minimum.

Causes of concern and recommendations

Cause of concern: leadership

Senior leaders in the force don't oversee custody services well enough to make sure that appropriate outcomes for detainees are achieved. There has been little improvement since our previous inspection and significant concerns remain. Oversight is limited by:

- not collecting some important information and having some information that is inaccurate;
- not using the performance information that is available to identify concerns and act on them;
- poor recording on custody records to show the detainee's journey through custody; and
- not having quality assurance arrangements to review custody records, assess how well services are provided and identify areas that need to improve.

In addition, the force doesn't make sure there are always enough custody personnel on duty to consistently meet detainee safety and welfare needs.

Our remaining causes of concern are largely due to the limited oversight in managing and improving custody services.

Recommendation

The force should robustly oversee custody provision with arrangements to adequately support this. These arrangements should allow for comprehensive assessment of how custody performs and be able to identify where improvements are needed. The force should act to achieve the improvement needed and be able to demonstrate changes as a result.

Cause of concern: use of force

The governance and oversight of the use of force in custody isn't good enough. The information to support effective scrutiny isn't accurate. It is drawn from use of force forms with no cross-referencing to custody records. Use of force forms aren't always submitted. There is no quality assurance of incidents. South Wales Police doesn't review incidents on CCTV, and our CCTV review found they weren't always managed well. There is limited oversight by custody officers. The force can't show that when force is used in custody it is necessary, justified and proportionate.

Recommendation

South Wales Police should scrutinise the use of force and restraint in custody to show that when it is used it is necessary, justified and proportionate. This scrutiny should be based on accurate information and robust quality assurance. Custody officers should appropriately oversee any incidents of use of force in custody.

Cause of concern: reviews of detention

The force isn't always meeting the requirements of PACE code C when carrying out reviews of detention. These are often of a poor standard and not conducted in the best interests of the detainee.

Recommendation

The force should comply with PACE code C when conducting reviews of detention and carry them out in the best interests of the detainee.

Cause of concern: healthcare

The approach to meeting detainee physical and mental health needs isn't good enough. In particular:

- The healthcare contract doesn't allow for healthcare practitioners to be embedded in all the custody suites. This adversely affects the continuity of care for detainees and can lead to delays in them being seen.
- The arrangements for referring detainees with suspected mental health conditions to mental health nurses aren't appropriate. Detainees with suspected mental health conditions are referred to the healthcare practitioner, who decides whether a referral to a mental health nurse is required. Healthcare practitioners don't have the required knowledge and training in mental health, or the necessary health information, to make such decisions. It means some detainees needing professional mental health help may not receive it and leads to delays for those detainees who are referred.

Recommendation

The force should make sure detainees receive prompt healthcare that allows for continuity of care. Mental health professionals should assess detainees with suspected mental health conditions and decide the most appropriate action to take.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HMICFRS and CQC. These inspections are part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The national rolling programme of police custody inspections, which began in 2008, makes sure that custody facilities in all 43 forces in England and Wales are inspected regularly.

OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of, and conditions for, detainees. HMICFRS and CQC are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force fulfils its responsibilities when detaining people in police custody, and the outcomes for them. This includes how safely they are managed and how respectfully they are treated.

Our assessments are made against the criteria set out in our *Expectations for police custody*. These standards are underpinned by international human rights standards and are developed by the two inspectorates. We consult other expert bodies on them across the sector and they are regularly reviewed. This helps to achieve best custodial practice and promote improvements.

The expectations are grouped under five inspection areas:

- leadership, accountability and working with partners;
- pre-custody – first point of contact;
- in the custody suite – booking-in, individual needs and legal rights;
- in the custody cell – safeguarding and healthcare; and
- release and transfer from custody.

The inspections also assess compliance with the PACE 1984, its codes of practice and the College of Policing's Authorised Professional Practice – Detention and Custody.

The methodology for carrying out the inspections is based on:

- a review of a force's strategies, policies and procedures;
- an analysis of force data;
- interviews and focus groups with personnel;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also analyse a representative sample of custody records from all suites in the force area for the week before the inspection starts. For South Wales Police, we analysed a sample of 100 records. The methodology for our inspection is set out in full at Appendix I.

Terminology in this report

Our reports contain references to, among other things, 'national' definitions, priorities, policies, systems, responsibilities and processes.

In some instances, 'national' means applying to England and Wales. In others, it means applying to England, Wales and Scotland, or the whole of the United Kingdom.

Section 1. Leadership, accountability and working with partners

Expected outcomes

Chief officers have a clear priority to protect the safety and well-being of detainees and to divert vulnerable people away from custody.

Leadership

South Wales Police has clear governance arrangements for the provision of custody services. An assistant chief constable has overall responsibility for custody, with a chief superintendent having the lead for custody as part of the wider operational support services portfolio. A dedicated superintendent and chief inspector are responsible for managing custody services. We found senior leaders take an active interest in custody.

However, despite this, progress since our last inspection has been limited and several areas of concern remain. Senior leaders don't have robust enough oversight. This is a cause of concern.

The force has a strategic plan for custody, which fits into its wider force operational plans. It monitors progress against the plan and custody services at several operational and strategic meetings including:

- monthly operational support services meetings where updates on custody matters are discussed;
- custody demand and performance group meetings, held every two months and chaired by the custody superintendent, which consider how well custody is meeting demand and how custody services are provided;
- resource management board meetings, held every two months, which review resources for custody including staffing levels in the suites;
- individual meetings between the chief superintendent and the superintendent for custody to discuss more detailed custody matters; and
- meetings chaired by the superintendent with the custody inspectors to discuss custody operations and deal with day-to-day matters arising.

The force meets regularly with its healthcare provider to monitor the contract and assess how promptly detainees receive assessment and care. However, the contract is limited in how well it can meet the healthcare needs of detainees. The contract has been extended. It is being re-tendered but progress is slow.

The force manages its custody services across four custody suites at Cardiff, Swansea, Bridgend and Merthyr Tydfil.

The two suites at Bridgend and Merthyr Tydfil are modern with good facilities. Cardiff is of a reasonable standard, but Swansea is dated. There are potential ligature points in all suites and in the cells at Cardiff and Swansea. Many of these were present at our previous inspection and the force has taken little action to address them. We gave the force a physical conditions report during this inspection, and it started to respond to some of the concerns raised.

The force monitors the number of personnel working in custody so that it can best meet demand. At the time of our inspection, there were vacancies and resource was significantly reduced due to sickness, some of which was long-term.

To address this, the force offers overtime to those working in custody. But we saw personnel were stretched at busy times and weren't always able to carry out all the duties expected of them. This includes providing showers or exercise for detainees. It also led to some long waits for detainees before they could be booked in.

Inspectors weren't able to carry out reviews of detention when they were due and weren't always available to take complaints.

Initial training for custody personnel is comprehensive and follows the nationally approved course developed by the College of Policing. There is a period of shadowing and a workplace assessment with more experienced custody personnel before duties are carried out independently.

Ongoing continuing professional development training is more limited, with the force providing one day a year. Additional time is given for personal safety training. Recent training has covered mental health, neurodiversity awareness and dPER completion.

There are good processes to report and investigate adverse incidents within custody. Personnel understand what is required of them and any learning is shared at meetings and through emails to custody personnel.

The force has adopted the College of Policing's APP guidance for custody but doesn't always follow this. For example, officers routinely remove clothing from detainees rather than make an individual risk assessment, and not all custody personnel are present at shift handovers. Of the personnel we spoke to, few had good knowledge of the guidance content.

Accountability

The force collects a range of information to manage custody performance, including:

- the number of detainees entering custody;
- waiting times;
- average detention lengths;
- refused detentions; and
- strip search data.

But some important information isn't collected such as:

- how long detainees wait for a mental health act assessment;
- when reviews are carried out; and
- aspects of detainee care.

And some information is inaccurate, especially on use of force, where incidents are potentially under-recorded. This makes it difficult to assess outcomes for detainees.

Custody is managed at the custody demand and performance group meeting. The performance information is presented on a dashboard and discussed. Any matters of concern are escalated to senior leadership team meetings.

However, it isn't clear how senior managers use performance information to improve custody services. Despite information being available, and discussions taking place, some areas show little improvement. And concerns we identified during this inspection hadn't been recognised through the force's own performance management arrangements. This limited approach to managing performance is part of our cause of concern about leadership.

The force generally follows PACE and its codes of practice but doesn't always do so for reviews of detention. These often don't meet the requirements of PACE code C, paragraphs 15.1–15.14. For example, some detainees aren't given the opportunity to make any representations or informed by inspectors that their detention is being further authorised. Reviews rarely happen on time, and many are very early. Inspectors struggle to cope with the volume required. Reviews of detention are a cause of concern.

The governance and oversight of the use of force in custody aren't good enough and haven't improved since our last inspection. Although the use of force is reviewed by the force's use of powers board, the data on use of force incidents in custody isn't accurate. Not all incidents are properly recorded on custody records, and not all custody personnel complete use of force forms. There is no routine quality assurance of the use of force, and incidents aren't viewed on CCTV. Our CCTV review found incidents weren't always managed well. The force can't assure itself or the public that, when force or restraint is used in custody, it is necessary, justified and proportionate. This is a cause of concern.

The quality of recording on custody records also isn't good enough. We saw some detailed custody entries, but in most records important information was missing or wasn't accurately recorded. For example, there was little use of free text in risk assessments to provide more detail or information to show if and when detainees had received care provisions such as food and drink. Use of standardised pre-populated text led to confusing and contradictory entries, especially for reviews of detention and some general cell visits.

There are few quality assurance arrangements to dip sample custody records and assess how well services are provided at the different stages of the detainee's journey through custody. The standard and quality of recording on custody records and the lack of quality assurance are part of our cause of concern for leadership.

The force understands its responsibilities under the public sector equality duty, and has a strong strategic focus on equality, diversity and inclusion. It has provided training on subjects such as mental health conditions and neurodiversity, but not all custody personnel have received this. The force monitors disproportionality data for some aspects of custody, for example, strip searching, and discusses this at strategic and other senior management meetings. However, ethnicity isn't always recorded on custody records and this limits the effectiveness of monitoring.

The force is open to external scrutiny. Independent custody visitors (ICVs) visit suites regularly. They complete checklists following their visits, and any issues are normally dealt with at that time. ICV volunteers report a good working relationship with the force. The ICV scheme manager is involved in regular panel meetings with custody personnel.

The force also responded positively to our inspection findings, quickly starting work to improve the service provided to detainees in custody.

Working with partners

The force aims to divert children and vulnerable adults away from custody and the criminal justice system. It works with the youth justice service to support children and address the causes of offending behaviour. There are some good diversion schemes based in custody to support children and vulnerable adults. These include an intervention scheme for children and a women's pathfinder scheme.

The force has worked at a strategic level with the other forces in Wales, the Welsh Government and local authority children's services to find ways of securing alternative accommodation for children charged and refused bail. A scheme was developed but it wasn't cost effective. This situation hasn't improved since our last inspection and children are rarely moved as they should be.

Support for people with mental health conditions in and outside custody isn't good enough. There is limited partnership work at a strategic level between the force and mental health services to try and improve this. Some information is gathered, but the force doesn't know how long detainees wait for mental health act assessments or, where required, for mental health beds. The arrangements for referring detainees to the mental health nurse in custody aren't appropriate and need to change. Detainees wait too long for assessments or for bed spaces to become available. Police officers frequently spend long periods at other places of safety waiting for assessments under the mental health act. Outcomes for people with mental health conditions are poor.

Section 2. Pre-custody – first point of contact

Expected outcomes

Police officers and staff actively consider alternatives to custody. They effectively identify vulnerabilities that may increase individuals' risk of harm. They divert children and vulnerable adults away from custody when detention may not be appropriate.

Assessment and diversion at first point of contact

Frontline officers have a good understanding of what makes a person vulnerable. They said factors such as age, mental health or other health concerns, and alcohol and drug misuse all contribute to vulnerability, as well as the circumstances that a person might find themselves in. When deciding whether to arrest, officers take account of vulnerability, the severity of the offence and any safeguarding concerns.

The force provides training to help officers recognise and approach vulnerability. This covers adverse childhood experiences, mental health and domestic abuse. Training is held in person and online. There is also information displayed in police buildings to prompt officers to think about vulnerability.

Officers told us that the information they receive from the call handlers in the force's control room to help them deal with incidents is generally good and provided promptly. If they need further information, they can ask for it or use their own laptop or mobile device to obtain it – although this depends on having a good enough signal.

Officers try to avoid arresting children where possible. Although the severity of the offence and any need to safeguard the child or others influence the decision for arrest, officers told us they explore alternatives where possible. These include voluntary attendance interviews, restorative justice options, or taking children home to parents or another relative while trying to resolve the incident. Officers also refer children to the youth offending services and neighbourhood policing teams, who can support them to try and prevent offending behaviour. School liaison officers also support children.

We were told unless the reasons for arresting a child can be clearly justified, custody officers refuse to detain them in custody. However, we found a few cases where detention was authorised but officers had given little consideration to alternatives. In our view custody could have been avoided in these cases.

Support for frontline officers dealing with people with mental health conditions isn't always good enough. The mental health crisis teams provide telephone advice, but officers told us they aren't always able to speak with someone and that the advice given doesn't always help them decide what to do. When they can't contact anyone in the crisis teams, officers sometimes ring the NHS 111 service.

Until recently, mental health professionals were based in the force's control room offering help and advice. Officers said this service was better because it helped them to decide whether detaining a person under section 136 of the Mental Health Act 1983 was appropriate or if other health options were available. It is too early to assess how the changes to mental health advice for officers are affecting outcomes for people with mental health conditions. However, it is clear that officers are sometimes making decisions on what to do based on limited mental health advice.

Officers take people detained under section 136 for a mental health act assessment, but there are long waits at hospitals or mental health facilities. This is a poor outcome for detainees and poor use of police time. Detainees should be transported by ambulance, but long waits for these mean officers normally transport them in police vehicles.

When a person has committed an offence but shows signs of a mental health condition, officers normally arrest and take them into custody. They consider the severity of the offence and the detainee's behaviour when deciding if custody is appropriate. Any health needs are dealt with in custody, and the investigation into the offence continues pending any health decisions being made.

Police vans are used to transport detainees to custody. Police cars are sometimes used if vans aren't available. There are no specific arrangements for people with mobility difficulties. Officers told us they would use vans or police cars and said this could make it difficult to maintain the detainee's dignity.

Area for improvement

Officers dealing with people in mental health crises should have enough advice and information available to them to help decide the most appropriate action to take.

Section 3. In the custody suite – booking-in, individual needs and legal rights

Expected outcomes

Detainees are treated respectfully in the custody suite and their individual needs are identified and met. Detainees' risks are identified at the earliest opportunity and managed effectively. Detention is appropriately authorised. Detainees are informed of their legal rights and can freely exercise these rights while in custody.

Respect

Custody personnel are patient and reassuring and treat detainees with respect. There are privacy barriers between custody desks, but when the suites are busy sensitive conversations can sometimes be overheard. Custody officers usually offer detainees the opportunity to speak to a member of custody personnel in private during the booking-in process.

All cells are covered by CCTV, but there are limited notices in the suites pointing this out. Detainees aren't routinely told that there is CCTV in cells, or that the toilets are obscured from view. Despite this, some toilet areas aren't sufficiently obscured. Also detainees aren't routinely given toilet paper and have to ask for it. This reduces detainee dignity.

Most of the suites have showers that provide enough privacy for detainees, but in Cardiff the showers have low doors, which limits detainee privacy.

Detainees are usually given suitable replacement clothing and plimsolls if their own clothing and shoes are removed, although we saw some detainees weren't wearing footwear when walking around the suites. When detainees have all their own clothing removed for safety reasons, they are given anti-rip clothing instead but they don't always put this on. Officers give little encouragement for them to do so, and some detainees remain naked in cells.

Area for improvement

The force should strengthen its approach to detainee dignity by:

- informing all detainees that the suites are covered by CCTV and that the toilet area in cells with CCTV is obscured;
- making sure that the toilet areas in all the cells are fully obscured from view on the CCTV; and
- taking steps to avoid detainees remaining naked in their cells.

Meeting diverse and individual needs

Custody personnel understand how to meet the individual and diverse needs of detainees and try to meet these as best they can.

Custody suites have various facilities to meet the needs of detainees with disabilities, including hearing and visual impairments and physical disabilities. For example:

- Wheelchairs are in suites and are in good condition.
- All suites except Swansea have sight lines (markings to help visually impaired people to judge the position of walls and obstructions) in the cells.
- All suites have hearing loops although some custody personnel don't know how to use them.
- Merthyr Tydfil and Bridgend both have an adapted cell, although the cell at Bridgend is used for storage purposes. There are also adapted showers and toilets.
- All suites have easy read versions of rights and entitlements. There are also braille versions but custody personnel at Bridgend couldn't find these.
- All suites except Swansea have extra thick mattresses but some of these are in poor condition.

The force could do more to meet the needs of women. Female detainees aren't always offered a female officer to speak to. At booking-in, females are asked if they require feminine hygiene products, but the range of products is limited in some suites.

Custody personnel generally understand the needs of neurodivergent detainees and are aware of how the custody environment may affect them. They told us that they had received training on this. All the suites have distraction materials available. It isn't clear how often these are given out, although we saw foam balls given to detainees.

Custody personnel have some understanding of how to meet the needs of transgender detainees.

Detainees aren't usually asked if they have caring responsibilities for others. This hasn't improved since our last inspection.

There is a good range of religious items covering all the main religions to allow detainees to observe their faith. Religious books and items are stored appropriately in separate boxes, but the Quran wasn't always stored high enough. Custody personnel have received little training on how to handle religious items and there is no guidance in the suites about this.

There is good provision for detainees who speak little or no English and the force uses LanguageLine for interpreting services. At Cardiff, Bridgend and Merthyr Tydfil separate telephones at the booking-in desk are used to speak with interpreters. But at Swansea a speakerphone is used, which means there is little privacy.

Area for improvement

The force should strengthen its approach to meeting the diverse and individual needs of detainees by:

- always asking detainees if they have caring responsibilities for others;
- making sure a range of female menstrual products is available; and
- making sure all custody personnel have a good understanding of different religious practices and how to handle religious items.

Risk assessments

The force is thorough in identifying risks when detainees enter custody, and generally manages these well. But it doesn't follow APP guidance in all areas of risk management.

Detainees are usually booked into custody promptly but can wait a long time in holding rooms when the suites are busy. Custody personnel don't manage queues well, rarely triaging risk or prioritising children and other vulnerable detainees. This doesn't follow APP guidance.

Initial risk assessments appropriately identify detainees' individual risks, vulnerability factors and welfare concerns. Custody officers interact positively with detainees and explain the purpose and importance of the risk assessment. They cross-reference information from previous custody records, the force's computer system and the Police National Computer. And they routinely ask arresting and escorting officers if they have any relevant information to contribute.

Custody officers generally set observation levels correctly to reflect the risk posed by the detainee and these are kept under review. Checks are usually carried out well and at the right time.

Detainees under the influence of alcohol or drugs are appropriately placed on level 2 checks with rousing every 30 minutes. Rousing checks are usually carried out and recorded well, meeting APP guidance. But we found some occasions when, in our view, the observation level was lowered too early with insufficient justification recorded. Also, there is a lack of continuity of custody personnel conducting cell checks. Continuity is important, as otherwise custody personnel may not recognise changes or any deterioration in a detainee's condition.

When custody officers identify detainees as high risk, they place them on higher levels of observation at either level 3 (constant observation by CCTV) or at level 4 (physical supervision at close proximity). The officers responsible for these observations are generally properly briefed by the custody officer on the risks the detainees pose and directed not to use their phones during the observations. However, we found some cases where the briefing wasn't good enough. Observing officers don't always keep a log of their observations for the custody record, as required by APP.

As found in our previous inspection, most custody officers continue to routinely remove any corded clothing and footwear from detainees, rather than making an individual risk assessment to decide this. This doesn't follow APP guidance. Custody officers don't always record when clothing has been removed or why it is justified.

Anti-rip clothing is used to manage detainee risk and protect them from self-harm. But there isn't always a good enough rationale for its use. In some of the cases we examined, the risks could have been better mitigated and managed through higher levels of observation such as level 3 or level 4. This hasn't improved since our last inspection.

Handovers between custody personnel include oral and written information and are properly focused on risk. But there is no collective handover between all the incoming and outgoing custody staff. Custody officers and custody detention officers carry out separate handovers and these don't involve HCPs. This means not all relevant information is shared with those taking over responsibility for detainees. These practices don't follow APP guidance. After the handover, custody officers visit and speak with the detainees in their care. Custody detention officers conduct their visits at the beginning of their shift. The handovers between shifts are recorded on CCTV.

Cell call bells are audible and can be answered via an intercom system. Custody personnel respond to them promptly in most instances. But in some cells the sound quality is poor, which makes communication difficult.

Custody personnel carry personal-issue anti-ligature knives while on duty. This means they can respond to potential self-harm incidents without delay.

Custody personnel manage cell keys well and always have control over who has them.

Area for improvement

The force should improve its approach to managing detainee risks by:

- only using anti-rip proof clothing when it is fully justified to manage detainee risks and protect them from self-harm. The reason for its use should be fully recorded;
- not routinely removing detainees' clothing, footwear and other items but deciding this based on an individual risk assessment;
- making sure handovers between shifts share information about the detainees' risks with all custody personnel on duty; and
- making sure the same custody detention officer conducts rousing checks to rouse intoxicated detainees on level 2 observations, where possible.

Individual legal rights – detention

Waiting times for detainees to be booked into custody varies. Some detainees are booked in promptly, but during busy periods detainees can wait a long time between their arrival at custody and detention being authorised. This was particularly the case at Cardiff. Custody officers don't prioritise the booking-in of children or vulnerable detainees. And they don't always record reasons for delays on custody records.

In general, custody officers authorise detention appropriately. Arresting officers usually give a clear account of the circumstances of the arrest and explain the necessity for it as required by PACE code G. But sometimes they could provide more detail. Custody officers don't always record enough information about why the arrest is necessary; instead they rely on standard drop-down menus with no other detail or rationale provided. This means it isn't clear how the necessity is linked to the circumstances of the arrest.

Custody officers refuse detention when necessary but we found some inconsistencies between them in deciding this. We found a few cases involving children where detention was authorised but, in our view, should have been refused.

Voluntary attendance is used as an alternative to taking a person into custody. There are voluntary attendance interview rooms so that people coming to the police station for an interview don't need to enter custody.

Some cases are progressed promptly, with appropriate use of bail to minimise time in detention. But some detainees spend longer than necessary in custody. Not all cases are dealt with expeditiously. Investigators aren't available 24 hours a day, so case enquiries are delayed, especially at night. We found many detainees waited a long time before being interviewed because enquiries hadn't been dealt with as quickly as possible. Some detainees were kept in custody for enquiries to be carried out when this could have been done before the arrest.

Custody officers clearly explain bail and any bail conditions to detainees. In the cases we reviewed the bail conditions were necessary and proportionate. Grounds for remanding detainees in custody after charge were also justified and clearly recorded.

Custody personnel contact immigration services promptly after detainees arrive in custody. But detainees can have long waits, sometimes for days, after their immigration papers (IS91 notice) are served before they are transferred to an immigration facility.

Area for improvement

The force should deal with investigations expeditiously to keep the detainee's time in custody as short as possible.

Individual legal rights – detainees' rights and entitlements

Custody officers provide clear explanations of rights and entitlements to detainees. These include:

- to have someone informed of their arrest;
- to consult a solicitor and access free independent legal advice; and
- to read the PACE codes of practice.

Custody officers explain these well and in a way that considers individual needs.

They provide detainees with written notices of their rights and entitlements. But we found that children, and others who might benefit, weren't always given easy read versions. And some suites don't have enough copies of PACE code C books for detainees to read.

Custody officers provide written translations of important documents in different languages for detainees who speak no or limited English, as required by PACE code C, annex M. Posters about the right to legal advice are displayed in custody suites in Welsh and English but not in other languages.

If detainees decline legal advice, custody officers ask them why, and we saw this being asked again before detainees went into an interview. We found detainees can exercise their rights without delay. Where rights are delayed – for example a detainee being kept incommunicado – this is appropriately authorised by inspectors. When the grounds no longer apply, the detainee's right to have someone informed of their arrest is reinstated.

Legal representatives attend custody in person. They are routinely given front sheets of custody records and can access the full record if needed. All custody suites have consultation rooms for private meetings between detainees and their legal representatives.

Detainees who are foreign nationals have the right to speak to somebody at their country's embassy, consulate or high commission at any time. Custody officers arrange this if requested. When custody officers are required to notify these bodies because an agreement exists with the relevant country, this is done.

There are no posters or leaflets in any of the custody suites to provide detainees with information about the process and policy for DNA retention and disposal. Detainees aren't always told about this when samples are taken. DNA samples are stored in unlocked freezers, which could affect their integrity. The samples are collected from the suites regularly.

Area for improvement

The force should strengthen its approach to individual rights by:

- having enough PACE code C books in all suites;
- giving easy read versions of the rights and entitlements to children or others who may benefit from them;
- displaying posters about the right to legal advice in other languages; and
- storing DNA samples in locked freezers.

Reviews of detention

Reviews of detention are poor and often don't comply with the requirements of PACE code C. They aren't conducted in the best interests of the detainee. This is a cause of concern.

Inspectors, who are appropriately authorised, carry out reviews of detention. But we were told there is no formal training for those responsible for conducting the reviews. We found reviewing inspectors didn't fully understand what is required of them.

Some inspectors carry out up to 60 reviews on their shift. We found they scheduled reviews to fit in with their workload rather than when they were due. We found many reviews were done several hours early, sometimes one or two hours after detention was authorised. These early reviews were often done when detainees were in rest periods. If they had been completed at the due time, the detainee could have been spoken to and been given the chance to make representations.

During the review, officers remind detainees of their rights and entitlements. But they don't always give detainees the chance to make representations, as required by PACE code C paragraph 15.3, or tell them that their continued detention is being authorised. Officers give little consideration to detainee welfare. Reviewing officers don't check how the case is progressing to help decide whether ongoing detention is necessary and justify why case enquires need to be done while the detainee is in custody. We found this included some cases for children where, in our view, ongoing detention wasn't justified.

If detainees are asleep or in interviews when officers carry out a review, they aren't routinely informed that this has taken place. This doesn't meet the requirements of PACE code C paragraph 15.7.

Reviewing officers often conduct reviews by telephone as it isn't practical for them to travel around the force area. Sometimes this works well, but the intercom system in the cells isn't always clearly audible. We observed a review where neither the inspector nor the detainee could hear what was being said. This limits the purpose and effectiveness of the review for detainees.

We found officers didn't always take account of the additional needs of children or vulnerable detainees when carrying out reviews. When reviews were done by telephone, officers didn't always record whether they had considered the benefits of doing this in person, as required by PACE code C paragraph 15.3C.

Officers copy and paste generic statements when recording reviews on custody records and use limited free text to make the review specific to a detainee. There are few tailored entries to reflect the discussion that took place or to show why further detention has been authorised.

During our inspection we raised our concerns with the force. Subsequently, the way that reviews are carried out improved.

Complaints

The complaints process for detainees isn't well promoted or clearly visible. Complaints notices are only on display in Cardiff and the information given is out of date. For example, the notices refer to the Independent Police Complaints Commission rather than the Independent Office for Police Conduct (IOPC). The notice doesn't inform a detainee they can make a complaint while in custody. Instead, it advises detainees to make complaints when they leave custody.

Detainees are given a copy of the Home Office rights and entitlements document that briefly explains how to make a complaint. But it doesn't provide any information specific to custody, or any contact details for the force or IOPC. None of the suites have IOPC leaflets containing contact information.

Some custody personnel we spoke to told us that detainees can make complaints while in custody and they would refer them to the custody officer or inspector. But others said detainees would have to wait until they left custody before being able to make a complaint.

Area for improvement

The force should make sure detainees can make a complaint before they leave custody.

Section 4. In the custody cell – safeguarding and healthcare

Expected outcomes

Detainees are held in a safe and clean environment, which protects their safety during custody. If force is used on a detainee this is as a last resort. Their care needs are met, and children and vulnerable adults are protected from harm. They have their physical and mental health, and any substance misuse, needs met.

Physical environment

South Wales Police has four designated custody suites at Bridgend, Cardiff, Merthyr Tydfil and Swansea. The general cleanliness in all the suites is good. Custody personnel told us that repairs are mostly completed quickly. Other than in Swansea, there is little graffiti in cells but there is graffiti in the exercise yards.

In Cardiff and Swansea there are potential ligature points in the cells. These are mainly due to the design of the toilets, air vents and cell door hatches. In all four suites, there are potential ligature points in the exercise yards and communal showers. During our inspection we gave the force a comprehensive report detailing these findings as well as those about the physical conditions in the suites more generally. The force started to respond to some of the concerns raised straightaway.

The ventilation and temperature in the suites and individual cells are generally satisfactory. All cells have natural light and toilets. All suites, apart from Swansea, have sinks for handwashing.

There are discrete booking-in areas in most suites. But personnel told us little, if any, use is made of them. All suites have at least one glass-fronted cell to help those who experience claustrophobia.

CCTV operates in all the suites but there are limited signs telling detainees about this.

CCTV monitors in all suites are positioned so that they can't be viewed by detainees or others in the main custody area. In some suites, the quality of the footage is poor. Toilets in all cells are pixelated but the camera isn't always adequately positioned to allow for privacy.

Officers carrying out level 3 CCTV observations of detainees sit in the custody desk area as there are no separate rooms where CCTV can be observed. This means they can become distracted from these duties when the custody suite is busy.

Custody personnel carry out and record safety checks twice a day, and store these on the force's computer system so that any concerns or issues can be easily found. The information is included in the briefing for the custody daily management meeting.

Generally, there is a good understanding of emergency evacuation procedures. Custody personnel we spoke to had received recent fire safety training. However, not all personnel have been involved in a practical fire evacuation of a custody suite. There are fire evacuation boxes in all suites with enough handcuffs and other equipment to manage an evacuation.

Area for improvement

The force should address the safety concerns caused by potential ligature points and where resources don't allow immediate rectification, manage the risks appropriately.

Use of force

When force is used in custody, incidents aren't always managed well. We reviewed a few cases where the use of force wasn't proportionate to the risks or threats posed. There is poor recording of incidents and little quality assurance, making it difficult for South Wales Police to show that when force is used in custody it is necessary, justified and proportionate. This hasn't improved since our last inspection and is now a cause of concern.

We examined custody records and viewed CCTV footage for 18 cases where force was used in custody. We found some good communication and negotiation by officers to attempt to de-escalate situations and avoid the need to use force.

However, in some cases we reviewed use of force incidents were poorly managed. We observed some restraint techniques weren't effectively applied, and officers failed to control the situation appropriately. This risked injury to the detainee and officers. Incidents weren't always overseen by custody officers, and in some cases custody officers were involved in the use of force rather than directing the incident.

When clothing was removed and replaced with anti-rip clothing, officers hadn't always considered other ways of managing risks. It wasn't always clear that removing clothing was necessary and justified. Clothing with cords is also routinely removed. In both circumstances, the use of force to remove clothing could potentially have been avoided.

In addition, officers don't pay enough attention to maintaining detainee dignity when removing clothing. Some intoxicated detainees were left with a blanket or clothing, but officers made little effort to encourage them to dress themselves. They therefore remained naked in their cell. In the cases we reviewed, it wasn't clear if cell CCTV remained in operation during the removal of clothing.

The recording of force on custody records is poor, and not all use of force incidents are recorded. When this did happen, the records didn't always reflect what we saw on the CCTV or explain why force had been necessary.

Information about the use of force isn't accurate. Officers don't always submit use of force forms when they should. This is a requirement of National Police Chiefs' Council guidance and there are notices in some suites reminding officers about this. For the incidents we reviewed, we asked for the use of force forms but didn't receive all the forms we were expecting. South Wales Police doesn't identify use of force incidents through custody records, which means some are missed. All of this means the use of force is potentially under-recorded.

There is no quality assurance over the use of force in custody. South Wales Police don't review incidents on CCTV to assess how they were managed or whether the force used was necessary, justified and proportionate.

We reviewed six cases where detainees were strip searched. The necessity for the strip searches wasn't always clear or adequately recorded. We found some cases where clothing had been removed to manage a detainee's risk but hadn't been recorded as a strip search. This means the information about strip searches is potentially inaccurate.

When a detainee arrives at custody handcuffed, the time the handcuffs are removed and the reasons why they were used isn't recorded.

Handcuffs aren't always removed quickly enough from compliant detainees. They can only be removed once authorised by the custody officer. We saw some compliant detainees were handcuffed for too long while in holding areas, waiting to be booked in. This sometimes led to an escalation of force and risk of injury to detainees and officers, which potentially could have been avoided.

Most custody officers and detention officers are up to date with their officer safety training and there are arrangements to train those who aren't.

We referred two cases to the force where we had concerns. In these cases, officers used techniques that, in our opinion, could have resulted in injury to the detainee.

Detainee care

The force has a reasonable approach to detainee care. We found custody personnel showed a caring attitude when interacting with detainees. Most detainees we spoke to felt that they had received good care in custody.

Detainees aren't always told about the care provisions available to them, such as showers, exercise areas or reading material, when they are booked into custody. This means they may not know what they are entitled to.

There is a good range of food, and most dietary requirements are catered for, including vegetarian, vegan and gluten-free. We saw food and drink offered and provided to detainees regularly. But empty food boxes aren't always taken away promptly.

The range of reading material in the suites is poor. Few children's books are available, although the force is arranging more child-friendly reading material. At Merthyr Tydfil, there are some books in French, German and Polish but there are generally few books in foreign languages. Books are kept in boxes but these are disorganised and there is no system for re-stocking reading material.

Distraction materials are available including Rubik's Cubes, fidget poppers, colouring books and foam balls. But, other than foam balls, we didn't see these offered routinely to detainees.

Showers are rarely offered, even for detainees who are in custody for a long time. There are very few towels in the suites.

Exercise yards are available in all suites, with some cover for inclement weather. But often exercise isn't offered or provided. When it is, detainees are supervised on CCTV.

There is a good supply of replacement clothing in a range of sizes, and underwear for both sexes is available. Plimsolls are available as replacement footwear.

Mattress quality is generally poor, providing little support or comfort for detainees. Some of the extra thick mattresses are also in poor condition. Mattresses are folded in half when not in use and this has damaged them. Pillows are routinely provided.

There are fleece-style blankets for detainees, as well as safety blankets. These aren't routinely given out and detainees usually have to ask for them.

Area for improvement

The force should improve the care for detainees by:

- making sure detainees are always informed of the care provisions available to them;
- offering and providing showers and exercise to detainees, especially those in custody for a long time;
- routinely offering distraction materials to detainees;
- making sure there is adequate reading material provision, especially books or magazines for children and more titles in foreign languages; and
- providing comfortable mattresses to detainees.

Safeguarding children and vulnerable people

Since our last inspection, the force has improved its approach to safeguarding children and other vulnerable detainees. It has introduced a force-wide safeguarding policy, which sets out the responsibilities and requirements, including in custody, for safeguarding children and vulnerable people. The force provides training to help personnel understand vulnerability. This includes child exploitation and adverse childhood experiences. We found personnel understood their safeguarding responsibilities and what was expected of them.

Arresting and investigating officers are expected to complete a public protection notice multi-agency safeguarding referral for every child detained and any person they consider to be vulnerable. In the cases we examined for detained children, these referrals had mostly been made. Cases were also flagged directly with other agencies such as children's services when appropriate.

There is an intervention scheme to help children in custody and divert them away from offending behaviour. This is run by Media Academy Cymru and funded by the police and crime commissioner. Youth workers based in custody offer detained children support to help improve their lives, such as educational courses, substance misuse services, and sporting initiatives. In most of the cases we reviewed children were offered these opportunities.

However, the force isn't making sure that children in custody are safeguarded as well as they could be. Girls are offered the opportunity to speak privately with a female member of custody personnel when they are booked into custody. But it wasn't clear that a named custody personnel member was assigned to, or spoke with, girls as required under the Children and Young Persons Act 1933.

HCPs don't routinely see children in custody. Doing so would give children additional support and help identify any safeguarding concerns.

Children are generally released from custody safely. However, we found some cases where it wasn't clear what consideration had been given to safeguarding. For example, in one case we reviewed, a teenage girl was released during the evening to an address where she didn't live and was expected to make her way there by herself.

Area for improvement

The force should comply with legal requirements by making sure all girls are assigned a same-sex member of personnel to look after their welfare in custody. The assigned person should speak with the girl and take an active interest in her welfare, and the details should be clearly logged on the custody record.

Appropriate adults

Custody officers are responsible for securing AAs to support children and vulnerable adults. When attending an incident, arresting officers also try, where possible, to arrange a suitable family member who can act as an AA.

Custody officers usually make early contact to arrange for an AA to attend and support the detainee. We found AAs arrived promptly in some cases. But some children and vulnerable adults waited a long time before their AA attended custody. And in some cases AAs didn't arrive until the time of the interview. This meant detainees missed the early support to help them understand their rights and entitlements and other custody processes.

Where friends and family aren't able to perform the AA role, other arrangements are made.

For vulnerable adults, the force uses Adferiad Recovery to provide support 24 hours a day, 365 days a year. Custody personnel generally spoke positively about the service, although they said securing AAs to attend at night was sometimes a challenge.

For children, the force relies on local authorities' youth offending teams during the day and the social services emergency duty team workers out of hours. We were told about problems with prompt attendance from both services, but particularly at night. This means children can spend longer in custody than is necessary.

Although AAs should be called to support vulnerable adults, we found this didn't always happen. This was because the custody officer hadn't recognised, or sufficiently considered, the detainee's vulnerabilities and so didn't arrange an AA.

The time when AAs are contacted is usually recorded on custody records, but other information is either missing or confusing. The force doesn't monitor how quickly detainees receive support. And the quality of information it collects means it wouldn't be able to do so with any accuracy.

In our last inspection, we identified support from AAs as an area for improvement. The force has made some improvements, for example, contact is now made earlier and rights and entitlements are re-read with the AA present. But some detainees are still waiting too long before receiving support.

Area for improvement

Children and vulnerable adults should receive prompt support from appropriate adults at all times, including at night. The force should collect and monitor information to show waiting times.

Children

Custody officers generally consider the detention of children robustly before authorising it. We saw some good examples where this had happened. However, we also found this approach was inconsistent and some cases might have been more appropriately dealt with away from police custody.

Some children spend a long time in custody and their cases aren't always dealt with quickly. In some cases, investigating officers aren't allocated promptly, particularly at night, when children waited until the morning before the case was assigned. Delays also occur when waiting for an AA to arrive. Inspectors reviewing children's detention don't place enough emphasis on how the case is progressing to minimise the time children spend in custody.

Quality of care for children in custody is mixed. They are rarely prioritised to be booked into custody, and little use is made of discrete facilities to keep children separate from adult detainees. Distraction items such as foam balls and Rubik's Cubes are available, but these aren't routinely offered. We didn't see children spending time out of their cells in the exercise yards or other areas of the suite. However, AAs were often allowed to sit with children in their cell.

The force recognises it needs to improve how it deals with children. It is taking part in an academic project to examine how to improve the experiences of children in custody. It hopes to learn from this to inform its approach.

The force monitors children in custody. Every detained child is discussed with senior officers at the daily management meeting. Children are also included in the performance management reports. The force examines all cases where a child has been strip searched to assess if this was conducted appropriately. But there is no regular review of children's cases to quality assure them and identify where improvements are needed. The force chairs a children and young person's multi-agency discussion forum. However, custody isn't always represented and there is no specific focus on custody matters.

Since our last inspection, there has been little progress to move children charged and refused bail to alternative accommodation arranged by the local authority. The force has an escalation procedure where individual cases are discussed at a senior level to explore potential solutions. It has also worked with other forces and local authority partners across Wales to consider how alternative accommodation can be provided. But despite these efforts there has been little change since our last inspection. In the 12 months before this inspection, none of the 26 children detained in these circumstances were moved to either secure or appropriate alternative accommodation as required.

Area for improvement

The force should deal with children in custody as quickly as possible, so they spend no longer than necessary in custody.

Area for improvement

The force should continue to work with local authority partners to improve the provision of alternative accommodation for children who are charged and refused bail.

Healthcare

Mitie provides physical healthcare support to detainees. Governance of the healthcare contract is satisfactory. The force monitors the contract and meets with Mitie regularly.

The contractual arrangements don't allow for HCPs to be fully embedded in the custody suites. This means detainee care isn't consistent across South Wales and limits the force's ability to meet detainees' healthcare needs. The force and Mitie recognise this is a weakness.

The healthcare contract is due to be renewed but progress in re-tendering has been slow.

Three HCPs cover Cardiff, Swansea and Merthyr Tydfil custody suites, and one forensic medical examiner covers Bridgend custody. The forensic medical examiner is often required to attend external appointments as part of the contract to cover sexual assault referral centres and sudden deaths. This leaves only three HCPs to cover four suites. Detainees are mostly seen within contractual timeframes, but healthcare staff are under significant pressure to achieve this, and it doesn't allow for continuity of care for detainees.

Practitioners and clinical leads carry out regular clinical audits to monitor and improve the quality and safety of care provided.

There are appropriate information-sharing arrangements between the force and its healthcare partners. However, HCPs are unable to access summary care records or community mental health records. This can cause delays in accessing health information about detainees and lead to subsequent delays in treatment.

Many HCPs have been recently recruited and there are few vacancies. Healthcare staff receive a comprehensive induction and online training, which includes safeguarding so they can recognise and manage detainees' vulnerabilities. However, not all healthcare staff feel supported in their roles and formal supervision isn't consistently recorded for HCPs.

Medical rooms are cleaned daily and temperatures are monitored to preserve the integrity of medicines stored in the room. But, due to general wear and tear of the decorations and flooring, none of the medical rooms comply with infection control guidelines. Emergency equipment, including oxygen, is available in each suite, and HCPs have access to automated external defibrillators.

Healthcare staff arrange interpreters for detainees whose first language isn't English.

Healthcare incidents are reported online and are investigated by managers.

There is a confidential complaints process for healthcare, but this isn't advertised to detainees in the custody suites.

Area for improvement

Medical rooms should comply with infection prevention and control standards.

Physical health

HCPs offer a good standard of care when they see detainees. But this is compromised because they aren't embedded in the suites. This creates delays in meeting detainee healthcare needs and also limits continuity of care, such as the ongoing monitoring of health conditions, because HCPs have to travel between suites and cover each other's roles.

Custody personnel make referrals to HCPs electronically. Senior clinicians oversee the system, managing response times and allocating HCPs between the suites where necessary.

HCPs request consent from detainees to carry out assessments of physical and mental health (including their mental capacity), substance misuse, social care and safeguarding.

Clinical assessments are completed to a good standard. Records are handwritten and stored securely in a locked cabinet. Most healthcare staff have access to the custody record to record a summary of their intervention. However, at the time of our inspection, some new HCPs were still waiting for training in how to do this. HCPs contribute to decisions regarding risk, such as fitness to detain and interview.

HCPs routinely see detainees with the medical room door left open, rather than risk assessing the need for this. This isn't private and confidential for the detainee. HCPs have privacy screens to use when intimate samples are taken.

Area for improvement

Medical consultations should take place in private with the door closed unless a risk assessment indicates otherwise.

Mental health

A mental health nurse, provided by three university health boards, works in each custody suite five days per week.

However, the arrangements for referring detainees with suspected mental health conditions aren't appropriate. Custody personnel refer detainees to the HCP, who sees the detainee and decides whether a referral to a mental health nurse is required. HCPs don't have the required knowledge and training to make such decisions. And they also don't have access to detainees' community mental health records to inform decision-making. This means some detainees who need professional mental health help may not receive it, and it leads to delays for those detainees who are referred. This is inappropriate and poor practice. It is a cause of concern.

Mental health nurses can access community mental health team records in their university health board area but have to telephone if they need information from other areas.

Mental health nurses don't screen all detainees in custody to identify whether they are known to services. They offer an assessment to detainees with mental health conditions who are referred to them by the HCP. They make referrals to other agencies and for community follow-up and signpost detainees to help and support when they leave custody. When the mental health nurses are on duty and, if requested, they support the process to refer a detainee for a mental health act assessment. When they aren't on duty, the HCP is responsible for referrals.

Custody personnel have good relationships with mental health nurses. But they also told us the service provided is too restricted, and detainees with suspected mental health conditions don't always receive the support they need while in custody.

Mental health nurses record interactions with detainees on the university health board electronic record system. A summary is also recorded on the custody record to make sure the appropriate risk and safety information is shared with custody personnel.

Custody isn't used as a place of safety under section 136 of the Mental Health Act 1983. However, there are significant delays when trying to access health-based places of safety for detainees requiring urgent assessment of mental health.

Waits for medical professionals to attend sometimes cause delays to mental health act assessments carried out in custody. When detainees are assessed as requiring detention under the Mental Health Act, there are significant delays because of the lack of available secure beds. This leads to detainees spending a long time in custody.

The force doesn't collect information to show how long detainees wait to be assessed under the Mental Health Act while in custody and how long they wait for a secure bed if required. The force and mental health services meet regularly but outcomes for detainees remain poor.

Police officers can telephone the mental health crisis teams to help them deal with incidents involving people with mental health conditions on the street. There is no dedicated control room support or street triage service available across the force area.

Substance misuse

Support for detainees with substance misuse needs is very good. Substance misuse practitioners are embedded in the custody suites seven days a week. Following positive feedback and uptake of the service, a pilot is underway to extend the provision to include nighttime cover.

Substance misuse practitioners offer a voluntary assessment to all detainees in custody, and when they aren't available, custody staff complete a referral form and the practitioner deals with this the following day.

Substance misuse practitioners liaise with community drug and alcohol services to allow continuity of care. They refer detainees who aren't currently involved with drug and alcohol services to a single point of access referral team to make sure the most appropriate service is found for the individual.

HCPs assess and provide treatment for detainees withdrawing from drugs and alcohol while in custody. They use nationally recognised clinical tools to inform their decision-making and monitor detainees' treatment needs while in custody. When clinically indicated, healthcare staff administer medicines to relieve symptoms of withdrawal.

There are arrangements for detainees to continue their prescribed opioid substitution treatment medication while in custody. This is very good practice. Substance misuse practitioners liaise with pharmacies to check the detainee's medication and whether it is appropriate to be collected and issued to the detainee in custody. Where appropriate, the practitioner, detainee and custody sergeant sign a consent form and police officers collect the prescription. The medication is booked into custody and stored securely in the detainee's property locker. HCPs administer the

medication, and this information is shared with prison healthcare staff where the detainee is recalled to prison.

Medicines management

Medicines are stored appropriately and administered to detainees in line with national guidance. The provider has patient group directions to support healthcare staff with decision-making on health issues such as asthma, pain and acute withdrawal from alcohol and drugs.

The healthcare provider doesn't offer nicotine replacement therapy to detainees, but this is available from custody personnel.

There are good governance arrangements to manage medicines safely. Medicines, including controlled drugs, are stored safely and are subject to daily audits and stock checks. Custody personnel store detainees' own labelled medicines securely in the detainees' property lockers, and HCPs assess the detainee before administering these.

Section 5. Release and transfer from custody

Expected outcomes

Detainees are released or transferred from custody safely. Those due to appear in court in person or by video do so promptly.

Safe release and transfer arrangements

Custody officers generally make sure detainees are released safely. We saw some good attention and care given to detainees to help them get home.

Custody officers are supportive and interact well with detainees when releasing them. They carry out the pre-release risk assessment with the detainee present, and take account of the initial risk assessment and the detainee's behaviour in custody. They discuss any risks with the detainee and mitigate these as far as possible.

However, the recording on some pre-release risk assessments isn't good enough. We found some didn't include important information about the detainee's risks and weren't always clear on how a detainee was getting home.

Where detainees don't have the means to get home, custody officers make good efforts to help them by arranging for taxis or officers to take them home if needed.

Most custody officers are aware of the enhanced safeguarding arrangements for those arrested under suspicion of committing serious sexual offences. Release planning for these detainees starts when they arrive in custody and continues throughout detention. There is a good exchange of information with investigating officers. HCPs are involved with 'fit to release' assessments. Lucy Faithful Foundation support leaflets are available for detainees.

There are leaflets containing information about national and local organisations to support detainees when leaving custody. However, custody officers don't provide these directly to detainees. Instead, HCPs or the support agencies put them in the detainee's property locker. This means the force can't be sure all detainees receive the relevant support information.

Custody detention officers complete dPERs well. Custody officers thoroughly check and review the content of the dPERs, cross-referencing this with the force's computer system, Police National Computer warning markers and the custody record, before signing them off. Most custody officers interact well with detainees who are being transferred to court or prison. Custody officers provide an oral and written handover to the escort officers ensuring the detainee's risks are understood.

Courts

The escort contractor takes detainees held overnight for court promptly in the morning. Detainees are suitably dressed to attend court.

The courts accept detainees later in the day, usually up until 2pm. Police officers transport these detainees to court. This means detainees aren't held in police custody for longer than necessary.

The force has virtual court facilities but these are rarely used.

Section 6. Summary of causes of concern, recommendations and areas for improvement

Causes of concern and recommendations

Cause of concern: leadership

Senior leaders in the force don't oversee custody services well enough to make sure that appropriate outcomes for detainees are achieved. There has been little improvement since our previous inspection and significant concerns remain. Oversight is limited by:

- not collecting some important information and having some information that is inaccurate;
- not using the performance information that is available to identify concerns and act on them;
- poor recording on custody records to show the detainee's journey through custody; and
- not having quality assurance arrangements to review custody records, assess how well services are provided and identify areas that need to improve.

In addition, the force doesn't make sure there are always enough custody personnel on duty to consistently meet detainee safety and welfare needs.

Our remaining causes of concern are largely due to the limited oversight in managing and improving custody services.

Recommendation

The force should robustly oversee custody provision with arrangements to adequately support this. These arrangements should allow for comprehensive assessment of how custody performs and be able to identify where improvements are needed. The force should act to achieve the improvement needed and be able to demonstrate changes as a result.

Cause of concern: use of force

The governance and oversight of the use of force in custody isn't good enough. The information to support effective scrutiny isn't accurate. It is drawn from use of force forms with no cross-referencing to custody records. Use of force forms aren't always submitted. There is no quality assurance of incidents. South Wales Police doesn't review incidents on CCTV, and our CCTV review found they weren't always managed well. There is limited oversight by custody officers. The force can't show that when force is used in custody it is necessary, justified and proportionate.

Recommendation

South Wales Police should scrutinise the use of force and restraint in custody to show that when it is used it is necessary, justified and proportionate. This scrutiny should be based on accurate information and robust quality assurance. Custody officers should appropriately oversee any incidents of use of force in custody.

Cause of concern: reviews of detention

The force isn't always meeting the requirements of PACE code C when carrying out reviews of detention. These are often of a poor standard and not conducted in the best interests of the detainee.

Recommendation

The force should comply with PACE code C when conducting reviews of detention and carry them out in the best interests of the detainee.

Cause of concern: healthcare

The approach to meeting detainee physical and mental health needs isn't good enough. In particular:

- The healthcare contract doesn't allow for healthcare practitioners to be embedded in all the custody suites. This adversely affects the continuity of care for detainees and can lead to delays in them being seen.
- The arrangements for referring detainees with suspected mental health conditions to mental health nurses aren't appropriate. Detainees with suspected mental health conditions are referred to the healthcare practitioner, who decides whether a referral to a mental health nurse is required. Healthcare practitioners don't have the required knowledge and training in mental health, or the necessary health information, to make such decisions. It means some detainees needing professional mental health help may not receive it and leads to delays for those detainees who are referred.

Recommendation

The force should make sure detainees receive prompt healthcare that allows for continuity of care. Mental health professionals should assess detainees with suspected mental health conditions and decide the most appropriate action to take.

Areas for improvement

First point of contact

Officers dealing with people in mental health crises should have enough advice and information available to them to help decide the most appropriate action to take.

In the custody suite – booking-in, individual needs and legal rights

The force should strengthen its approach to detainee dignity by:

- informing all detainees that the suites are covered by CCTV and that the toilet area in cells with CCTV is obscured;
- making sure that the toilet areas in all the cells are fully obscured from view on the CCTV; and
- taking steps to avoid detainees remaining naked in their cells.

The force should strengthen its approach to meeting the diverse and individual needs of detainees by:

- always asking detainees if they have caring responsibilities for others;
- making sure a range of female menstrual products is available; and
- making sure all custody personnel have a good understanding of different religious practices and how to handle religious items.

The force should improve its approach to managing detainee risks by:

- only using anti-rip proof clothing when it is fully justified to manage detainee risks and protect them from self-harm. The reason for its use should be fully recorded;
- not routinely removing detainees' clothing, footwear and other items but deciding this based on an individual risk assessment;
- making sure handovers between shifts share information about the detainees' risks with all custody personnel on duty; and
- making sure the same custody detention officer conducts rousing checks to rouse intoxicated detainees on level 2 observations, where possible.

The force should deal with investigations expeditiously to keep the detainee's time in custody as short as possible.

The force should strengthen its approach to individual rights by:

- having enough PACE code C books in all suites;
- giving easy read versions of the rights and entitlements to children or others who may benefit from them;
- displaying posters about the right to legal advice in other languages; and
- storing DNA samples in locked freezers.

The force should make sure detainees can make a complaint before they leave custody.

In the custody cell – safeguarding and healthcare

The force should address the safety concerns caused by potential ligature points and where resources don't allow immediate rectification, manage the risks appropriately.

The force should improve the care for detainees by:

- making sure detainees are always informed of the care provisions available to them;
- offering and providing showers and exercise to detainees, especially those in custody for a long time;
- routinely offering distraction materials to detainees;
- making sure there is adequate reading material provision, especially books or magazines for children and more titles in foreign languages; and
- providing comfortable mattresses to detainees.

The force should comply with legal requirements by making sure all girls are assigned a same-sex member of personnel to look after their welfare in custody. The assigned person should speak with the girl and take an active interest in her welfare, and the details should be clearly logged on the custody record.

Children and vulnerable adults should receive prompt support from appropriate adults at all times, including at night. The force should collect and monitor information to show waiting times.

The force should deal with children in custody as quickly as possible, so they spend no longer than necessary in custody.

The force should continue to work with local authority partners to improve the provision of alternative accommodation for children who are charged and refused bail.

Medical rooms should comply with infection prevention and control standards.

Medical consultations should take place in private with the door closed unless a risk assessment indicates otherwise.

Section 7. Appendices

Appendix I – Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and throughout their time in custody to their release. We visit the force over two weeks. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for police custody*.

Document review

Forces are asked to provide various important documents for us to review. These include:

- the custody policy and/or any supporting policies, such as the use of force;
- health provision policies;
- joint protocols with local authorities;
- staff training information, including officer safety training;
- minutes of any strategic and operational meetings for custody;
- partnership meeting minutes;
- equality action plans;
- complaints relating to custody in the six months before the inspection; and
- performance management information.

We also request important documents, including performance data, from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template based on police custody data for the previous 36 months. The template requests a range of information, including:

- custody population and throughput;
- the number of voluntary attendees;
- the average time in detention;
- children; and
- detainees with mental health problems.

This information is analysed and used to provide background information and to help assess how well the force performs against some main areas of activity.

Custody record analysis

We analyse a sample of custody records drawn from all detainees entering custody over a one-week period prior to the start of our inspection. The records are stratified to reflect throughput at each custody suite and are then picked at random. Our analysis focuses on the legal rights and treatment and conditions of the detainee.

Case audits

We audit around 40 case records in detail (the number may increase depending on the size and throughput of the force inspected). We do this to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include examining records for children, individuals with mental health problems, those under the influence of drugs and/or alcohol, and cases where force has been used on a detainee.

Our audits examine a range of factors to assess how well detainees are treated and cared for in custody. Audits examine, for example, the quality of risk assessments, whether observation levels are met, the quality and timing of PACE reviews, whether children and vulnerable adults get support from appropriate adults when they need it, and whether detainees are released safely. We also assess whether force used against a detainee is proportionate and justified, and is properly recorded.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing their physical conditions, observing operational practices, and assessing how detainees are treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first-hand. We also speak to other non-custody police officers, solicitors, health professionals and other visitors to custody to get their views on how custody services operate. We examine custody records and other relevant documents held in the custody suite to assess how detainees are dealt with, and whether policies and procedures are followed.

Interviews with personnel

During the inspection we interview officers from the force. These include:

- chief officers responsible for custody;
- custody inspectors; and
- officers with lead responsibility for areas such as mental health or equality and diversity.

We speak to people involved in commissioning and running health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak to the co-ordinator for the Independent Custody Visitor scheme for the force.

Focus groups

During the inspection we hold focus groups with frontline response officers and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

Feedback to force

The inspection team provides an initial outline assessment to the force at the end of the inspection, to give it the opportunity to understand and address any concerns at the earliest opportunity. Then we publish our report within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit about one year after our inspection to assess progress against our recommendations.

Appendix II – Inspection team

- Ian Smith: HMICFRS inspection lead
- Patricia Nixon: HMICFRS inspection officer
- Anthony Davies: HMICFRS inspection officer
- Emmanuelle Versmessen: HMICFRS inspection officer
- Nicola Duffy: HMICFRS inspection officer
- Justine Wilson: HMICFRS inspection officer
- Marc Callaghan: HMICFRS inspection officer
- Vijay Singh: HMICFRS inspection officer
- Julie Mead: HMICFRS inspection officer
- Stephen Matthews: HMICFRS inspection officer
- Dayni Turney: CQC inspector
- Lynda Day: CQC inspector

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