HMICFRS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

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

by HM Inspectorate of Constabulary and Fire & Rescue Services and HM Inspectorate of Prisons

8–19 November 2021

Contents

Fact page

Note: Data supplied by the force.

Force

North Wales Police

Chief constable

Carl Foulkes

Police and crime commissioner

Andrew Dunbobbin

Geographical area

North Wales (local authority areas: Wrexham, Flintshire, Denbighshire, Conwy, Gwynedd, Anglesey)

Date of last police custody inspection

2014

Custody suites

- Llay Custody, Davy Way Industrial Estate, Llay LL12 0PG: 32 cells
- St Asaph Custody, St Asaph Business Park, Saint Asaph LL17 0HQ: 32 cells
- Caernarfon Custody, Maesincla Ln, Caernarfon LL55 1BU: 16 cells

Annual custody throughput

9,490

Custody staffing

- 1 superintendent
- 1 chief inspector custody lead
- 1 inspector custody policy, compliance and support

St Asaph

- 1 inspector
- 12 sergeants
- 12 custody detention officers

Llay

- 1 inspector
- 12 sergeants
- 10 custody detention officers

Caernarfon

- 1 inspector
- 12 sergeants
- 8 custody detention officers

Health care staffing

- 1 custody nurse manager
- 4 custody nurse team leaders
- 12 custody nurses

Mountain Healthcare Ltd. provides governance of health care.

Summary

This report describes our findings following an inspection of North Wales Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP) in November 2021. 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.

This inspection took place during the COVID-19 pandemic. We continue to adapt our ways of working to manage the risks as the pandemic continues. We gave the force more notice of the inspection than usual. And we carried out our case reviews and analysis, interviews and focus groups remotely. We made our observations over the two-week period, but we limited the number of our inspectors in the custody suites at any one time.

We last inspected custody facilities in North Wales Police in 2014. We found that, of the 22 recommendations made during that previous inspection, the force has fully or partially achieved 15 of them.

To help the force improve, we have made four recommendations to them (and the police and crime commissioner). These address our main causes of concern. We have also highlighted a further 17 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and partnerships

There is a clear governance structure in place to check that custody services are safe and respectful. Oversight is generally good and focused on making improvements.

The force has three custody suites – at Llay (Wrexham), St Asaph and Caernarfon. It monitors staffing levels to make sure that absences are covered, and custody can be provided safely.

It has adopted the College of Policing's Authorised Professional Practice – Authorised Professional Practice – Detention and Custody (APP). The force also has its own custody policies and guidance. But these aren't always followed, especially when managing risk. We also found inconsistent practices in some aspects of custody provision.

The force monitors performance but some important areas aren't included, such as detainee waiting times. Some of the information collected is inaccurate, which means that custody provision isn't assessed as well as it could be. The force is developing a 'performance dashboard' to include more information.

There are several areas where the force doesn't always meet the requirements of legislation and guidance, as set out in the Police and Criminal Evidence Act 1984 and its codes of practice. These include: giving the necessity for and explaining the circumstances of arrest; explaining the detainee's rights and entitlements; reviews of detention; and custody officers' involvement in investigations in a way that compromises the independence of their role. This is a cause of concern.

Governance and oversight of the use of force in custody isn't good enough. There is a use of force scrutiny board, but its monitoring isn't effective enough. This is because of some missing or inaccurate information about what force was used, by which officers, and why it was necessary. We found that force was often used in custody, and often to forcibly remove clothing from detainees. It is difficult for North Wales Police to show that when force is used in custody, it is necessary and proportionate. In some of the cases we saw on CCTV, it is our view that it wasn't. This is a cause of concern.

The quality of recording on custody records is poor. Some entries are detailed, but important information was missing from some records. This includes, for example, the justification for removing detainees' clothing. And some information is inaccurate, such as the recorded times of cell visits. The force's quality assurance of these records isn't good enough. This is a further cause of concern.

However, recording and reporting adverse incidents in custody, and learning from them, is good (an adverse incident means any incident which, if allowed to continue to its ultimate conclusion, could have resulted in death or serious injury to any person). The force is also open to external scrutiny from independent organisations and groups with an interest in custody.

The force understands the public sector equality duty. (This relates to the force's duty to consider how its policies and decisions affect people protected under the Equality Act 2010.) It monitors disproportionality in custody services to make sure that outcomes for detainees are fair, and it acts to address any concerns.

The force is committed to diverting children and vulnerable adults away from custody. It works with other organisations to offer diversion schemes to prevent and reduce offending. It also works with its local authority and mental health partners to help keep children and people with mental ill health out of custody.

Pre-custody: first point of contact

Frontline officers understand vulnerability and take account of this when deciding whether to make an arrest. They only take children to custody after exploring other alternatives.

The Criminal Justice Liaison Service (CJLS) mental health professionals working in the force's control room offer good support. This assists officers dealing with people who have suspected mental ill health. And it can help avoid detaining them under

section 136 of the Mental Health Act 1983. However, such support isn't as easily available when the mental health professionals aren't on duty. During these times, officers often can't speak to anyone in the mental health crisis teams or other organisations to get the information and advice they need.

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

Custody staff are respectful, calm and confident when dealing with detainees. They also give time to those who are most vulnerable. Detainee privacy and confidentiality are generally well maintained. But some practices for removing and storing detainees' clothing are disrespectful, with clothing sometimes left in the corridor.

There is some good provision for people with individual needs. Welsh language is used orally when needed and bi-lingually on all important printed information. Interpretation in other languages is arranged for people who have difficulty understanding English. Women are treated with care and respect. But provision for people with disabilities is inconsistent. Detainees are rarely asked if they have any religious needs and the stock of religious materials is limited.

The approach to identifying risk is generally good. But there are significant weaknesses in managing risk. Some ways of working mean that the force isn't ensuring detainees' safety. This is a cause of concern.

Custody officers generally carry out initial risk assessments and set observation levels correctly. Observation checks are usually on time. But some ways of working don't follow APP guidance. Sometimes there is a disproportionate response to managing risk. For instance:

- Different custody detention officers often complete the observation checks. This means that changes in a detainee's behaviour or condition might not be picked up.
- Custody detention officers don't always rouse detainees on Level 2 in the right way (Level 2 requires rousal checks that get an active response from the detainee). And these checks aren't always properly documented.
- Custody officers routinely remove clothing with cords and footwear from detainees rather than making an individual risk assessment. Officers rarely record the justification for this.
- Anti-rip clothing to manage detainees' risks is used frequently, often without adequate reasons why, and without it being properly recorded. Other ways of managing the risks aren't always considered.

Most detainees are booked into custody quickly, and detention is appropriately authorised. But the circumstances of, and grounds for, arrest aren't always explained in front of the detainee. Custody officers give good explanations to detainees about their rights and entitlements. But they don't always give them written information, as required by Police and Criminal Evidence Act 1984 (PACE) Code C paragraph 3.2.

The force seeks to progress cases as quickly as possible so that detainees don't spend longer than necessary in custody. Reviews of detention aren't always carried out well enough, but most are in person and on time. Detainees released under investigation receive a notice about the offences they may be committing if they interfere with victims or witnesses while the investigation is in progress. But custody officers don't always explain this to them.

The force's approach to complaints while individuals are in custody is poor. There is little promotion of how to make a complaint, not all officers are clear about the procedures to follow and detainees wishing to make a complaint while in custody aren't always able to do so before they are released.

In the custody cell, safeguarding and healthcare

General conditions in the three custody suites vary. This is due to the age and design of the buildings, but they are clean and cells are well maintained. There are potential ligature points in all suites, mainly due to the design of toilets and sinks.

Detainees are generally cared for well. Those we talked to spoke highly of the care they were given, especially those who were vulnerable or distressed. Food and drinks are offered throughout the day. But staff aren't proactive enough in offering and providing other aspects of care such as showers or reading material.

Officers and staff generally understand their responsibilities to safeguard vulnerable adults and children. But arrangements to secure appropriate adults to support children and vulnerable adults don't always result in the adults arriving early enough. This is especially the case outside normal working hours. And we are not assured that appropriate adults are always called for vulnerable adults who may need one.

There is a good focus on keeping children in custody for the shortest time possible. Children receive good care while in custody. Few are charged and refused bail. But when this does happen, they are not moved to local authority-arranged accommodation as they should be because there is little available.

A competent and well-trained nursing team see most detainees promptly and meet their health needs. But patient confidentiality is sometimes compromised when nurses ask detainees questions when they are being booked in, rather than in private.

The force works with organisations that provide support for detainees who are drug and alcohol users. This includes referring detainees to a drug education programme. But the health care contract does not require opiate substitution therapy (OST) to be available. This is poor and isn't in line with national guidance.

CJLS offers good support to detainees with mental health needs. We were told that mental health act assessments in custody weren't often required but could be arranged fairly quickly if necessary.

Release and transfer from custody

Custody officers make sure that detainees are released safely and that they can get home. Police officers take children and vulnerable adults home when it is not possible to release them into the care of a responsible adult.

Digital person escort records (dPERs) – which provide information about the detainee and any risks for the escorting agency – for detainees attending court or who have been recalled to prison are fully completed. Custody officers check and sign these off.

Detainees remanded for court are generally collected promptly in the morning. This is good for the detainee as it keeps the time they are held in police custody to a minimum. This is an improvement since our 2014 inspection.

Causes of concern and recommendations

Cause of concern: Meeting legal requirements and guidance

The force doesn't always comply with the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. There are several areas where the requirements aren't always met. These include:

- those relating to the necessity for, and the circumstances of, arrest;
- providing detainees with written copies of their rights and entitlements;
- reviews of detention; and
- custody officers directing investigations.

Recommendation

The force should take immediate action to make sure that all custody procedures and practices comply with legislation and guidance.

Cause of concern: Use of force

North Wales Police's governance and oversight of the use of force in custody are limited. Information on what force is used, by which officers, or why it is necessary is often incomplete or inaccurate. It is often used to forcibly remove clothing with little justification shown or evident. There are few reviews of incidents on CCTV to assess how well they are handled or whether the force used is necessary and proportionate. Our review of incidents suggests that sometimes it was not.

Recommendation

The force should scrutinise the use of force in custody. This should be based on accurate information and robust quality assurance, including viewing CCTV footage of incidents. It should use this to show that when force is used in custody, it is necessary and proportionate.

Cause of concern: Quality of custody records

The quality of recording on custody records is poor. This is because:

- important information is sometimes missing or inaccurately recorded;
- the reasons and justification for decisions isn't always clear;
- entries are often a mix of pre-populated standard text, alongside information on what had been done – making them confusing to understand; and
- quality assurance isn't effectively assessing the standard of records or identifying concerns.

This makes it difficult to establish how detainees have been treated in custody, and whether all processes have been applied correctly.

Recommendation

The force should make sure that the information recorded in custody records is accurate and complete. It should clearly reflect the individual action taken and the reasons for any decisions for each detainee. The force should robustly quality assure custody records to identify and act on any concerns.

Cause of concern: Detainee safety and risk assessment

The force is not managing detainee risks well enough because:

- Different custody detention officers carry out checks so there is often little continuity to assess changes in a detainee's demeanour.
- Rousal checks are not always conducted in the correct way or properly documented.
- Custody officers continue to routinely remove clothing with cords and footwear without an individualised risk assessment and it isn't always documented when or why clothing has been removed.
- Anti-rip clothing continues to be used frequently, often without adequate rationale. On occasions, this appears pre-emptive and in many cases is justified only because the detainee didn't answer the risk assessment questions. This is a risk averse approach, which often leads to clothing being unnecessarily and forcibly removed.
- Areas where staff carry out constant CCTV monitoring (authorised professional practice (APP) Level 3) are not covered by CCTV.
- Detainees queuing to be booked in aren't triaged to prioritise them.
- Custody staff do not maintain sufficient control and oversight of custody keys.

These practices do not follow APP guidance and potentially place detainees at significant risk of harm.

Recommendation

The force should take immediate action to mitigate the risk to detainees by making sure that its risk management practices follow APP guidance and are carried out and recorded to the required standard.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Constabulary & Fire and Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP). 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 joint HMICFRS/HMIP national rolling programme of unannounced 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. HMIP and HMICFRS 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 drive improvement.

The expectations are grouped under five inspection areas:

- leadership, accountability and partnerships;
- pre-custody: first point of contact;
- in the custody suite: booking in, individual needs and legal rights;
- in the custody cell: safeguarding and health care; and
- release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) 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 staff;
- 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 North Wales Police we analysed a sample of 94 records. The methodology for our inspection is set out in full at Appendix I.

Section 1. Leadership, accountability and partnerships

Expected outcomes

There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

The force has a clear governance structure for monitoring the safe and respectful provision of custody services and to support continuous improvement. An assistant chief constable has overall responsibility for the provision of custody services. A superintendent and a chief inspector are responsible for the day-to-day operation of the suites.

Oversight arrangements are generally good, and meetings are focused on improving custody services:

- The custody chief inspector holds a monthly custody manager meeting. Attendees include custody managers, the custody nurse manager, officers from professional standards and training officers. They discuss various custody matters and examine performance.
- The strategic operational board considers custody matters and some areas of custody performance.
- The strategic planning and organisational learning board considers: HMICFRS recommendations; complaints; and any recommendations issued by the Independent Office for Police Complaints.
- A local criminal justice board, chaired by the police and crime commissioner, also oversees custody provision.

The force provides custody services in three suites – at Llay (Wrexham), St Asaph and Caernarfon. To manage custody services in all three locations, there are:

- three custody inspectors;
- one support inspector responsible for policy;
- 36 custody officers; and
- 30 custody detention officers (CDOs).

The force employs its own custody nurses, but clinical governance is through a contract with Mountain Healthcare (MHC).

Staffing levels are monitored daily and any absences are generally covered by moving staff between the suites. The force is managing higher absence levels because of COVID-19 cases and self-isolation restrictions. This means that more police officers are acting as 'gaolers' to cover CDO absences. However, gaolers can't carry out all the duties of a CDO, such as using Livescan for fingerprinting (a system used for confirming a detainee's identity). Officers we spoke to that were carrying out these duties told us that they hadn't all been trained on these duties and some weren't confident in carrying out this work.

The force is trying to achieve a better gender balance by addressing the lack of female custody staff. With the current imbalance, it is sometimes difficult to provide a female member of staff to support women in custody. On occasions, custody nurses do this even though it is not appropriate for their role.

Staff training is good. All custody and detention officers complete an initial custody course. They then shadow more experienced staff and complete a competency portfolio before they start their full duties. After this, training includes three continuous professional development days. Two of these are for first aid and officer safety training, while one day covers topics such as managing risk, domestic abuse and understanding neurodiversity.

The force has adopted the College of Policing's Authorised Professional Practice (APP). It also has its own custody policies and guidance. We found that these weren't always followed, particularly when managing risk. We observed differences in ways of working in the three suites, and sometimes between staff on different shifts. For example, we saw inconsistencies around when to remove handcuffs, and how the booking-in process was conducted.

There hasn't been a death in custody in North Wales since our inspection in 2014.

Area for improvement

The force should make sure that all custody staff follow the College of Policing's APP (Detention and Custody), as well as its own guidance. This will mean that detainees receive an appropriate and consistent level of treatment and care.

Accountability

Performance is monitored at the meetings described above. Other organisations are also involved in some performance monitoring. This includes the number of detainees entering custody, children in custody, and strip searching. But important information is missing. This includes waiting times for detainees to be booked into custody, average detention times and the number of times of anti-rip clothing is used. The force is developing a 'performance dashboard' to include more information.

Some of the information collected by the force is inaccurate or incomplete. For example, not all custody officers record the time detainees arrive in custody correctly. And some information is difficult to extract from the force's custody system because it is captured as free text or not in the correct way. For example, waiting times to see the health care professional, the time detainees wait for Section 2 of the Mental Health Act assessments, and the use of restraint equipment. This makes it more difficult for the force to monitor and assess custody provision.

Recording and reporting adverse incidents in custody is good. Staff are aware of their responsibilities and all incidents are recorded as part of the custody incident reporting process. Lessons learned from investigations are shared with staff through the 'need to know' bulletins and a custody newsletter.

The force doesn't always meet the requirements and guidance as set out in the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. For example:

- The circumstances of arrest aren't always explained to the custody officer in the presence of the detainee, which doesn't meet the requirements of paragraph 3.4 of Code C.
- The 'necessity test' given by arresting officers to meet Code G isn't always good enough.
- Detainees aren't routinely given a written copy of their rights and entitlements, which doesn't follow paragraph 3.2 of Code C.
- Reviews of detention don't always meet the requirements of PACE Code C.
- Custody officers are routinely involved in investigations. They carry out primary investigation reviews to assess evidence and direct further enquiries. This goes beyond their role of chasing up investigations and compromises the independence of their role. It is contrary to section 36(5) of PACE.

The number of areas not meeting the requirements of PACE is a cause of concern.

Force and restraint are used often in custody. The number of incidents involving the use of force or restraint is higher than we expect to see and have seen in other forces. Our examination of custody records, CCTV footage and our observations in suites suggest force and restraint is used often, including for forcibly removing clothing.

Governance and oversight of the use of force isn't good enough and is a cause of concern. The strategic use of force scrutiny board considers the use of force in custody, but is hindered by inaccurate information. This means that North Wales Police can't show that when force is used in custody it is necessary and proportionate. In some of the cases we examined, it is our view that it was not.

Not enough detail is recorded on detention logs to determine what force is used, by which officers, or why it is necessary. Not all staff complete the individual use of force forms in line with the National Police Chiefs' Council guidance. Some officers were unclear when they had to. There is little quality assurance of incidents against CCTV footage to show how well incidents are handled or that the force used is proportionate and justified. Overall, the quality of information to support effective scrutiny isn't good enough.

The quality of recording on custody records is poor and is a cause of concern. While we did see some very detailed entries on custody records, important information isn't always recorded (for example, the justification for removing detainees' clothing or when appropriate adults are called). Some information isn't recorded accurately, such as the time cell visits take place, and detainees' self-defined ethnicity.

Custody records are often a mix of standard pre-populated text reminders to the officers completing them, and the actions carried out. This is particularly the case for detainee checks and PACE reviews. This can make the record confusing to read and hard to understand.

Custody inspectors 'dip sample' 20 records every month. But these checks haven't picked up all the concerns or the differences in ways of working that we found. The inspectors also quality assure the records from the suites they are responsible for. More might be gained by inspectors looking at records from a suite that isn't one they work at. A recent move to monitoring 'live' records is expected to improve this.

The force understands the public sector equality duty. Staff told us that they had received training in identifying and managing the diverse needs of detainees. The force monitors disproportionality in custody services. This is to make sure outcomes are fair and there are specific actions to address any concerns. But showing fair outcomes is difficult because the self-defined ethnicity for many detainees isn't properly recorded.

The force is open to external scrutiny from independent organisations and groups with an interest in custody. Independent custody visitors (ICVs) have good access to the suites, conducting regular visits to each of them. (ICVs are volunteers from the local community who make unannounced visits to check on the treatment and welfare of detainees.) Custody staff respond quickly to any issues raised, and the chief inspector and ICV scheme manager monitor this.

The police and crime commissioner chairs the strategic executive board, which the chief constable attends, and important custody information is discussed. The force's independent advisory group and some community groups also offer external scrutiny.

Area for improvement

The force should strengthen its approach to performance management by collecting and monitoring accurate information for its main services, and showing the outcomes achieved for detainees.

Strategic partnerships to divert people from custody

There is a clear strategic priority to divert children and vulnerable people away from custody. Staff are aware of and understand this. The force works well with other organisations to offer diversion pathways and schemes to prevent and reduce offending. These include:

- early intervention and prevention activity coordinated through prevention hubs at Caernarfon, St Asaph and Llay;
- the Checkpoint scheme, which offers an alternative to a criminal justice disposal for adults who successfully complete the scheme;
- a women's pathway scheme with bases at Rhyl, Bangor, and Wrexham;
- a drug referral scheme; and
- a range of Criminal Justice Liaison Service (CJLS) initiatives.

The force works with its mental health partner organisations to identify, and meet the needs of, people with mental ill health. CJLS mental health professionals work in the force's control room. When on duty, they provide valuable support for police officers dealing with incidents on the street and in custody.

The force also works with its six local authorities, and with organisations in some of the wider Wales partnership arrangements, to improve outcomes for children in custody.

Section 2. Pre-custody: first point of contact

Expected outcomes

Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

Assessment at first point of contact

Frontline officers understand vulnerability. They consider factors such as mental ill health, and learning or physical disabilities. They treat all children as vulnerable because of their age. There is a force definition of vulnerability. But officers told us that they use their judgement to assess a person's individual circumstances when attending an incident and deciding whether it is appropriate to make an arrest.

The force has provided face-to-face training to help officers understand the different types of vulnerability. This covered mental health, domestic abuse and how children may be affected by poor life experiences. But officers told us that their training is often through e-learning rather than face to face, which they said would be more beneficial.

There has also been some training on the 'early help' referral scheme. Officers can use the scheme to get vulnerable people help from other organisations, such as housing services. These people are potentially at risk of offending and the hope is that early help will prevent or reduce this risk.

Officers told us that the information call handlers in the force control room (who take calls from members of the public) give them could sometimes be better. Officers don't always receive all the information held about individuals, or may not receive it in time to help them deal with the incident. They can ask for further information and call handlers do their best to provide it. Officers can also get information from their own mobile devices, but this relies on a good phone signal and the time to search. Despite these difficulties, officers generally feel that they have enough information to decide what to do.

Officers explore other ways of dealing with incidents involving children to keep them out of custody if possible. For example, they:

- arrange voluntary attendance interviews instead of taking a child into custody;
- take children to other family members if a situation needs calming down;

- discuss the situation with children's social services to see if they can offer support; or
- use a community resolution for a low-level offence.

Sometimes, the seriousness of an offence, or escalating repeat offending, means that arresting the child is the only option. But officers said they must robustly justify any arrest of a child to the custody officers when arriving at the suite.

Officers told us that they receive good support from the mental health professionals working in the force's control room. These professionals provide advice and assistance to help officers deal with people with mental ill health. This includes speaking directly to the person to better understand their needs. Officers value the service and said that, in their view, it helps avoids detaining a person under section 136 of the Mental Health Act 1983 by finding other solutions.

Officers said that when the mental health professionals aren't working (they work between 11.00am and midnight), help is more limited. They often can't speak to anyone in the mental health crisis teams or other organisations to get the information and advice they need. Officers told us that this increased the likelihood of them detaining people under section 136. This is to better manage the risk that the person poses to themselves and others.

Officers take people detained under section 136 to a mental health suite (a health-based place of safety) for a Mental Health Act assessment to be carried out. Police custody can only be used as a place of safety in exceptional circumstances. None of the officers we talked to could recall a case where this had happened. Officers told us that an agreement between the force and mental health services means that detainees shouldn't wait longer than 30 minutes at the mental health suites. But sometimes there is a longer wait before the person can be handed over to NHS mental health professionals. This is poor use of officers' time and a poor outcome for the person in mental health crisis.

Officers arrest a person if they have committed an offence unless it is clear that they need immediate medical attention. The custody nurse deals with any mental health needs identified in custody. The investigation continues unless a Mental Health Act assessment determines that the detainee needs to transfer to a mental health unit. Officers reported that occasionally the detainee is further detained under section 136 in custody because the Mental Health Act assessment in custody can't be arranged quickly enough, or the detainee's condition deteriorates.

Detainees are usually transported to custody in police cars. Ambulances are called for those going to mental health suites, but a police officer goes with them. If an ambulance cannot attend and a police car is used for these detainees, a paramedic should also be in the vehicle.

Area for improvement

Officers should always have access to advice from mental health services to help them deal with people with mental ill health appropriately.

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

Expected outcomes

Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

Custody staff deal well with detainees, but don't always give them enough individual attention. In general, staff are respectful, calm and confident with detainees, and give time and understanding to the most vulnerable. References to detainees and their behaviour in custody records are usually, but not always, respectful and appropriate.

But routine interactions with detainees during custody are often brief and functional, rather than building rapport with detainees. For example, during booking in, custody officers run through the list of questions about needs quite quickly. They always ask whether the detainee would like a private conversation with a member of staff. But, in our opinion and from what we saw, no-one said yes because it was said in such a complicated way. Similarly, custody detention officers carrying out their routine visits are friendly in tone, but often do little more than ask if the person is okay.

Custody officers don't often ask detainees whether they have dependants who might be affected by their detention.

Confidentiality is observed to a reasonable extent and detainees' personal information isn't displayed in suites. The layout of the main open area of the suites means that booking in is confidential most of the time. The booking-in desks are separated by substantial barriers and screens. However, at busy times people can overhear discussions between the detainee and custody officer. This can include potentially sensitive information.

Clothing is too often removed from detainees without sufficient reason (see Risk assessments). And it is sometimes cut off without enough regard to the dignity of the individual. At Caernarfon, detainees' shoes are routinely left on the floor in the corridor outside the cell. In some cases, clothes are left out too, including underwear. Showers at Llay and Caernarfon lack privacy (see Detainee care).

Areas for improvement

The force should improve its approach to detainee dignity and privacy by making sure that:

- staff communicate with detainees in a way that responds to their individual needs;
- detainees can disclose private or sensitive information in a confidential environment, including during the initial risk assessment;
- detainees can shower in sufficient privacy at all custody suites; and
- detainees' clothes are respectfully removed and always stored properly.

Meeting diverse and individual needs

There is generally good provision for peoples' diverse and individual needs. Important printed materials are available in Welsh. And it was good to see many staff switching easily between English and Welsh according to each detainee's preference.

Staff have received some good training in aspects of diversity, including neurodiversity. They can describe well how they have supported detainees with autism or attention deficit hyperactivity disorder (ADHD). The force has produced a booklet that gives an introduction to the custody experience. It is in an easy read, illustrated format, and includes the detainees' rights and entitlements. It is available in all suites.

Women are treated with care and respect. Menstrual products are freely available, and are mainly stored hygienically. But the system of assigning a nominated female officer to offer support for each woman isn't working well, and is often little more than a name on a custody record. A female member of staff is usually appointed as 'chaperone' for the female detainee. But the person may be someone who can't be available at short notice – or a nurse, whose professional role isn't entirely compatible with this operational role.

There is a wheelchair and a hearing loop at each suite. But providing physical adaptations for people with disabilities is inconsistent. However, the facilities at Llay are reasonably good.

Custody officers often don't ask the detainee to identify their own ethnicity, although an entry is made on the custody record. The question is sometimes asked in a leading way. For example, 'Are you white British?'.

Detainees who find it hard to understand English or Welsh, including foreign nationals, are generally given appropriate support. Staff are confident in using telephone interpreting services through dual handset phones. These allow privacy during conversations.

Staff have received training on the needs of transgender detainees. Staff described occasions where they have taken the correct approach to searching, and other aspects of support, for people with diverse gender identities.

Detainees are rarely asked if they have any religious needs. The stock of religious materials is limited to prayer mats and copies of the Qur'an and the Bible.

Areas for improvement

The force should strengthen its approach to meeting detainees' individual and diverse needs by making sure that:

- there is suitable provision for those with disabilities at all suites;
- all detainees are asked to identify their ethnicity;
- a female member of staff is readily available when assigned for female detainees, and carries out the role effectively; and
- there is an adequate supply of resources for the main religious faiths at all suites, and they are given to those who may want them.

Risk assessments

The approach to identifying risk is generally good, but there are significant weaknesses in risk management. Some ways of working mean that the force isn't always ensuring the safety of detainees. This is a cause of concern that we expect the force to address immediately.

Most detainees are booked into custody promptly. But during busy periods, they can wait a long time in holding rooms or vehicles before their detention is authorised. When queues form, there is little management to identify who should be prioritised for booking in.

When completing initial risk assessments with detainees, custody officers focus appropriately on identifying risks, vulnerability factors and welfare concerns. They interact well with detainees to complete the risk assessment. And they ask relevant supplementary and probing questions when required. There is routine cross-referencing to the police national computer warning markers to help identify extra risk factors. But arresting and escorting officers are rarely asked if they have any relevant information to add.

When more than one custody officer is on duty, it is clear who the designated custody officer for each detainee is. And this information is documented on records.

Observations of detainees are generally set at a level that is commensurate with the risks posed. The frequency of checks on detainees are mostly carried out as required. But the times of these checks aren't always accurately recorded. Different custody detention officers often complete the checks. This means that changes in a detainee's behaviour or condition might not be picked up.

Most detainees under the influence of alcohol and/or drugs are correctly monitored at a level that means they need to be roused, as required by level 2 in APP. But in cases we watched on CCTV, we saw that custody detention officers don't always rouse those on Level 2 in the right way to make sure that they remain safe. These checks aren't always properly documented. There is an over-reliance on pre-populated text,

which can be misleading, rather than accurately including the details of what the rousal check involved. As with other checks, different staff members often carry these out. This makes it more difficult to recognise changes in the detainees' condition – something that is particularly important for those under the influence of alcohol and/or drugs. These practices don't follow APP guidance.

Custody officers review observation levels regularly. They usually record enough information on custody records to show when and why they have been changed.

When the assessment indicates a higher level of risk, detainees are observed more closely at either:

- Level 3 (constant observation via CCTV); or
- Level 4 (physical supervision in close proximity).

Some of the areas where Level 3 monitoring takes place are not covered by CCTV cameras as required by APP guidance.

Custody officers brief staff conducting Level 4 observations (constant watches at cell doors). But this isn't always adequately noted on records. Officers conducting these duties often stay in post for long periods without a break. This doesn't follow APP guidance.

Regardless of presenting risks, custody officers – as in our 2014 inspection – routinely remove clothing with cords and footwear from detainees rather than making an individual risk assessment. There is rarely any recorded justification for this.

Custody officers – as in our 2014 inspection and the one previously – continue to use anti-rip clothing frequently, often without recording an adequate reason. Occasionally, the use of anti-rip clothing appears to be pre-emptive and as a first response rather than considering other ways of managing the risks. In many cases, the use of anti-rip clothing is justified simply because the detainee hasn't answered the risk assessment questions rather than any specific concerns about risks posed.

Detainees in anti-rip clothing are often placed on low-level observations. This suggests that their risks aren't considered significant. Some are left with items of underwear, which undermines the necessity for removing clothing in the first place. Even when detainees are on a higher level of observation, their clothing is often still removed. This is a disproportionate response to managing risk. And it leads to poor outcomes for detainees, particularly when force is used to remove clothing. It is our view that risks could be better managed by higher levels of observation and talking with detainees.

Handovers between shifts are recorded on CCTV. All custody staff, except health care professionals, are routinely involved and the focus is on risk and welfare. The health care professionals have their own handovers and then share any risk and welfare matters with custody staff. But it is our expectation, and APP guidance, that handovers should include all staff. Custody officers visit and interact with detainees in their care after the handover. This has improved since our last inspection.

It is good that all custody staff carry anti-ligature knives. Cell call bells are audible and there is usually a prompt response.

Cell keys are often left unattended in offices, which is poor. There is little oversight of when they are given to non-custody staff, which means custody staff aren't able to maintain control of them. Non-custody staff don't have access to anti-ligature knives, which means they can't respond quickly if they need to cut a ligature from a detainee.

Individual legal rights

Most detainees are booked into custody quickly. This was evident in the cases we reviewed and observed during our inspection. And officers confirmed that, generally, there were short waits for detainees to be booked into custody. During handover briefings and busy periods, waiting times were longer but not extensive. This is good for detainees.

Custody officers authorise detention appropriately. But the necessity for arrest isn't always given in enough detail to the custody officer to meet the requirements of PACE Code G. The circumstances of, and grounds for, arrest aren't always explained in the presence of the detainee as required by PACE Code C paragraph 3.4a.

The force uses alternatives to divert people away from custody when appropriate. Voluntary attendance is encouraged for interviews. Officers take detainees arrested on a warrant or for breach of licence conditions directly to the court or the prison where possible. This avoids the need for detainees to enter custody first. Out-of-court disposals are promoted through the Checkpoint scheme and the women's pathway programmes.

Detainees should be kept in custody for the minimum time necessary. The force seeks to progress cases as quickly as possible to achieve this. It has information on how long detainees spend in custody before they are released pre-charge, and their overall detention times. But this isn't routinely monitored.

Information provided by the force shows that the number of immigration detainees has significantly reduced over the last three years (from 193 in the period 1 November 2018 to 31 October 2019 to 13 for the same period 2020 to 2021). In 2020/2021 immigration detainees spent an average of 12 hours and 34 minutes in custody after they had been served with their immigration papers (IS91). Once these papers are served these detainees should be transferred by immigration services to an immigration facility.

Some, but not all, custody officers gave good explanations to detainees about their three main rights and entitlements. These are:

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

Detainees are not consistently given written information about their rights and entitlements. This doesn't meet the requirements of PACE Code C paragraph 3.2. The force has a booklet for detainees, which sets out their individual rights and entitlements. But this isn't always handed to them. The booklet also had some inaccuracies. However, when we pointed this out, the force arranged to update them.

There are posters advertising the right to free legal advice in English and Welsh in all suites. But there were no posters in other languages, in line with PACE Code C note 6H. The force was arranging to get these.

There are enough copies of the latest PACE Code C booklets (August 2019) in all the suites. But these aren't routinely offered to detainees as they should be (in line with PACE Code C paragraph 3.1).

None of the custody officers we spoke to were aware of the requirements of Annex M of PACE Code C (translation of important custody documents and records). We saw some detainees with a limited understanding of English who would have benefited from these translations.

There are copies of the easy read version of the booklet outlining detainees' rights and entitlements at all suites. But these aren't consistently offered to vulnerable adults, children or other detainees who would benefit from them.

There are enough interview and consultation rooms for detainees to consult with their legal representatives in private. Those wishing to speak to their legal representatives on the phone can also do so privately. Legal representatives can view a summary printout of the front sheet of their client's custody record on request.

Custody officers are aware of how to contact the relevant embassies, consulates or high commissions for foreign nationals coming into custody if a detainee requests this. They are also aware of the requirements to notify embassies, consulates or high commissions where agreements are in place to do so.

DNA is stored in locked freezers and regularly collected from the suites.

Area for improvement

Custody officers should consistently provide an easy read version of rights and entitlements to children, vulnerable adults and other detainees who would benefit from them.

Reviews of detention

Reviews of detention aren't always carried out well or in the best interests of the detainee. Many aspects don't meet the requirements of PACE Code C.

Most reviews are done in person by operational or custody inspectors, and are carried out on time. In the reviews we observed, detainees were treated courteously, and their welfare discussed.

However, detainees weren't always informed of all their rights or told that their continued detention was authorised. In some cases, detention was authorised before the detainees were given the opportunity to make any representations as required by PACE Code C paragraph 15.3.

We found that, in most cases we examined and observed where reviews had taken place while detainees were asleep, detainees weren't later informed of this at the

earliest opportunity. This is despite clear flagging on the custody record that this needs to happen. It was sometimes five to six hours before detainees were told. And they weren't always given their rights and entitlements again, or asked if they had any representations to make about their detention being further authorised. This doesn't meet the requirements of PACE Code C paragraph 15.7.

Access to swift justice

The force monitors people who are bailed or released under investigation. And regularly reviews overall performance, such as how many cases are in the system. Our custody record analysis showed that 43 percent of cases were finalised during the first period of detention. Detainees were bailed or released under investigation in the remaining cases.

Frontline supervisors are responsible for managing the investigations. But custody officers carry out an initial investigation review after a detainee is released under investigation. Actions are recorded so that the investigating officer understands what actions are required.

Custody officers don't always explain to detainees released under investigation the possible offences they may be committing if they interfere with victims or witnesses while the investigation is continuing. A notice outlining these is given to them, but they are just asked to read and sign it.

Complaints

The approach to complaints while detainees are in custody is poor. Detainees wishing to make a complaint while in custody aren't always able to do so before they are released.

Staff we spoke to weren't clear on the procedure for taking a complaint from a detainee. We were told that the detainee would be advised to call 101 once released, or they would inform the custody inspector rather than taking the complaint. We found examples of detainees wanting to complain but this wasn't recorded on the custody record or dealt with.

There is little promotion of, and little information on, how to make a complaint while in custody. The leaflet about the Independent Office for Police Complaints is outdated and refers to the previous Independent Police Complaints Commission.

The force provided details of ten complaints made during a six-month period to October 2021. Our findings suggest that there are more complaints than this but the force isn't capturing these.

Area for improvement

Detainees should be able to make a complaint easily, and before they leave custody.

Section 4. In the custody cell, safeguarding and health care

Expected outcomes

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent healthcare practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

Since our previous inspection in 2014, two part-time suites and a full-time suite at Wrexham have closed. The custody estate in North Wales now has three full-time designated suites – at Caernarfon, St Asaph and a new facility at Llay (Wrexham).

General conditions in the three suites vary due to the age and design of the buildings, but cells are well maintained, and cleanliness is good. Except for four cells at Caernarfon, there is some natural light in all cells, and no evident graffiti.

There are potential ligature points in all suites, mainly due to the design of toilets and sinks. During the inspection, we gave the force a comprehensive illustrative report detailing the ligature points, as well as general conditions.

Facilities vary in the suites. For example, cells at Caernarfon have benches that are either too high or too low to meet current guidance. Plus, only the cells at Llay have intercoms for remote communication.

There is a good quality CCTV system in all cells at Llay. At the other two suites, there is partial coverage of poor quality in some cells. Notices that CCTV is in operation aren't always prominently displayed where detainees can see them. And there are no notices in any of the cells covered by cameras.

Suites should have regular maintenance checks, but we found some gaps in the daily, weekly and monthly records. We were told that, in most cases, repairs are made quickly.

Most custody staff are aware of emergency evacuation procedures, and there are enough handcuffs to evacuate cells if needed. But few staff have taken part in a physical evacuation to make sure the procedures work in practice as required by fire regulations. There are no fire exit signs displayed in St Asaph.

Areas for improvement

- Notices advising that CCTV is in operation should be prominently displayed throughout the suites.
- The force should adhere to legal requirements for fire regulations, particularly around emergency evacuations. Appropriate fire exit signs should be displayed at St Asaph.

Safety: use of force

Custody staff are up to date with their personal safety training and take part in regular refresher training.

Information on custody records relating to the use of force is often limited, missing or incorrectly recorded. National Police Chiefs' Council (NPCC) guidance is that when any force is used on detainees it should be documented by each officer involved on an individual form. North Wales Police's policy (which it developed in consultation with external community groups) does not require use of force forms to be completed for 'soft physical force' which relates to compliant handcuffing. Staff told us that they didn't submit use of force forms for compliant handcuffing. But some staff are interpreting 'soft physical force' more widely and not completing forms. This means that use of force is not always being recorded when it should be. Based on the information available, it is not possible to know how often and what type of force is used in custody. This is a cause of concern.

Recording of the use of force accurately is further hindered because the North Wales Police computer system does not align with national recording guidelines. From the cases we assessed, and from our observations, we found 37 cases where the information suggested that force had been used. This is more cases than we have found in other forces' inspections. Although in a few of these cases, when we examined the CCTV footage, force had not actually been used.

Around two-thirds of the cases we examined involved the forcible removal of detainees' clothing. Again, this is much higher than we have seen in other forces. As described earlier in this report in risk assessment, it is our view that removing clothing isn't always necessary or justified. It is leading to some unnecessary use of force.

From the cases we reviewed on CCTV, we found some good examples where efforts were made to de-escalate situations. When force was deployed, techniques were generally used correctly. However, we also found some poor techniques and disrespectful practice. This included prolonged prone restraint and leaving detainees naked in cells. We referred these cases to North Wales Police for them to review and learn from.

There is some quality assurance of use of force incidents in custody. But we were told that few incidents are watched on CCTV footage. We were also told that anything considered to be 'soft physical force' wouldn't be reviewed.

In three cases, detainees had incapacitant spray used against them on arrest. There was no evidence of any aftercare given to those detainees during their time in custody.

The practice around the removing handcuffs varies between custody suites. Detainees don't always arrive in handcuffs. But when they do, some compliant detainees remain cuffed for too long, often because they are waiting for the custody officer's permission to have them removed.

We found few strip searches. Those we found were adequately justified and carried out appropriately.

Areas for improvement

- Detainees should receive appropriate aftercare when sprayed with incapacitant.
- Handcuffs should be removed from compliant detainees at the earliest opportunity.

Detainee care

Detainees are generally cared for well, but staff are not proactive enough in offering and providing some aspects of care. Most detainees we talked to spoke highly of the care given to them. Some – especially those who were vulnerable or distressed – said the staff were excellent.

Custody officers read the list of services to detainees when booking them in, but in practice they are rarely re-offered or provided. However, staff attitudes to detainees are good, and they respond positively and promptly to specific requests.

Food preparation facilities are good and kept clean. Food and drinks are freely offered throughout the day, although the range of food is more limited than we often see. We were told there were national supply problems for the delivery of microwave meals. This further limited the choices available for detainees at the time of our inspection. The force was trying to resolve these problems.

There is good provision for handwashing and hygiene, although the showers at Caernarfon and Llay are not sufficiently private. This is owing to their location and low swing doors (see Respect). From our observations, and in the records we examined, few detainees were offered or provided with showers. They were usually only offered to those who were attending court.

There is a good supply of clothing and blankets at each suite.

The exercise yards at each suite are suitable and big enough but exercise isn't routinely offered. We did find, however, that staff often suggest to detainees showing signs of stress that they might like some time in the exercise yard.

There is a good supply of books in the suites, mainly novels in English with a small number of foreign language books. There are very few magazines and no

newspapers. At Llay, there is a selection of books for younger people – which is good. Unfortunately, custody staff very rarely offer reading materials to detainees.

The force has produced distraction booklets with puzzles and other activities, and provides small boxes of coloured pencils to go with them. However, we didn't see any of these given to detainees during our visits.

Areas for improvement

The force should improve its care for detainees by making sure:

- detainees are offered the range of available services, including books, distraction materials, food, exercise or a shower; and
- a good range of food is always available.

Safeguarding

In general, frontline and custody officers and staff understand safeguarding and their responsibilities to vulnerable adults and children. This is supported by training to help staff understand vulnerability. This includes neurodiverse needs and adverse childhood experiences. Custody staff receive extra training on these subjects.

Arresting or investigating officers are primarily responsible for making referrals. We were told they would share safeguarding information with custody staff. But we found little or no recording on custody records about any safeguarding concerns that might need to be considered during custody. In some custody records we examined, it wasn't clear how a child was getting home safely after release.

The force is strengthening its approach towards safeguarding in custody. It has recently introduced a referral system for custody officers and others working in custody. This is to be used when any safeguarding concerns become evident during custody. This was set up in response to feedback from our child protection inspection in 2019. Custody staff were being trained on how to use the new system.

Force policy requires all children (and pregnant women) to be assessed by custody nurses while in custody. This is to make sure their health and wider welfare needs are addressed. But it wasn't clear from custody records that this always happened. Girls in custody are routinely assigned a female member of staff as a chaperone to look out for their welfare, as legally required by the Children and Young Persons Act 1933. However, it is not clear that girls are always told about this or that the chaperone speaks with them. Boys are also sometimes given a chaperone as an extra safeguarding measure where it is felt this may help.

Appropriate Adult (AA) support for children and vulnerable adults in custody isn't always prompt enough. The force is clear that AAs should be secured as soon as practical. We found some good examples of this happening, but also found some long waits with no clear reasons why.

Family members or friends are asked in the first instance. We saw some good examples of arresting officers doing this quickly. This meant the person attended

custody quickly to support the child early into their detention. Where friends or family can't act for children, Youth Justice Services are expected to attend during their working hours. Outside these times, there are different arrangements. In three of the force's local authority areas, the social services' emergency duty teams should provide someone. And in the other three areas, the force uses The Appropriate Adult Service (TAAS). These arrangements don't always make sure that AA support is available quickly enough.

Where family or friends can't attend for vulnerable adults, the force uses AAs from TAAS. This service is commissioned through the police and crime commissioner's office. The scheme started recently (having replaced a previous provider) and we were told it is working well.

Recording information on request and arrival times for AAs is limited. This makes it difficult to understand the reasons for any delays and for the force to show how well it is meeting the needs of children and vulnerable adults.

AAs aren't always considered for vulnerable adults when there is information to suggest that this should have happened. For example, we found cases where mental health or other neurodiverse needs indicated that an AA should have been considered but hadn't been.

There is guidance for those acting in the AA role, but this wasn't in every suite or was out of date. Where it was available, we didn't always see it given out or explained so that the person understood their role.

North Wales Police only detains children in custody where absolutely necessary and for the shortest time possible. Since 2018, the number of child arrests has reduced year on year. We found some good examples of using bail or releasing children under investigation rather than keeping them in custody unnecessarily. Information provided by the force shows that children in custody, particularly before they are charged, spend much less time in custody compared with adults.

Where children are detained, there are some good arrangements to help keep their anxiety or distress to a minimum. Distraction pack activities are available at all suites. These include puzzles, colouring and age-appropriate reading materials. These should be offered to every child in custody, but this doesn't always happen (see Detainee care).

All three custody suites have designated cells or areas that are usually allocated to a child to keep them separate from other detainees. At St Asaph, there are also dedicated exercise yards for both girls and boys. The custody staff we spoke to also gave examples of allowing some children to remain out of their cell. For example, alongside their parents or AA in a holding room.

The number of children charged and refused bail in North Wales is fairly low – seven between 1 November 2020 and 31 October 2021. These children should be moved from custody to either secure or appropriate (non-secure) accommodation. The local authority has a statutory responsibility to provide and arrange this. However, none of these children was moved as there is little or no accommodation available. Outcomes for children in these circumstances remain poor. The force continues to

work with the six local authorities in its area to try to improve the situation and is developing an escalation process with them for when accommodation isn't provided. The force also works with the wider all-Wales board, which is looking at the lack of secure beds throughout Wales.

The force monitors children in custody well. It recently strengthened this to address concerns raised in our child protection inspection in 2019. Custody managers review all cases of charged and remanded children. This is to make sure the correct type of accommodation has been requested and to identify lessons learned. In the three cases we assessed, the correct requests were made. There is also broader oversight of children in custody. This involves performance being discussed at custody and senior officer meetings, and at police and crime commissioner performance meetings.

Areas for improvement

- The force should strengthen its approach to AAs by making sure that:
  - all vulnerable adults in custody receive an AA; and
  - all children and vulnerable adults in custody are supported quickly, and information is collected to assess this.
- The force should continue to work with local authorities to improve the provision of alternative accommodation for children who are charged and refused bail.

Governance of health care

Governance arrangements have improved since our last inspection. They are now more effective in assuring safe care for detainees.

The force commissions Mountain Healthcare (MHC) to provide:

- clinical policies and procedures;
- oversight of the force custody nursing team; and
- telephone advice from forensic medical examiners when required.

There are few complaints (three or four a year), which are usually about medication. Complaints are well managed.

The contract with MHC is monitored through regular meetings and monthly performance and service data.

Staffing has improved since our last inspection. The team consists of an experienced custody nurse manager and well-led, competent team leaders and custody nurses. Together, they provide 24-hour cover at the custody suites. Nurses are well trained, several to an advanced level, and are regularly supervised.

Paper-based clinical records hold good information. But they are time consuming to prepare and make auditing inefficient. Team leaders assess a sample of nurses' records each month to make sure they are meeting the required standards.

The treatment rooms at Llay and St Asaph are very good, but the one at Caernarfon is too small and poorly located. Equipment checks and infection control measures are regularly audited to monitor safety. Medical rooms are only used for seeing and treating detainees, which minimises the likelihood of DNA contamination. Nurses carry out forensic sampling at each suite.

Emergency resuscitation equipment is kept in each custody booking-in area and in each medical room. This includes automated external defibrillators and other personal protective equipment. Custody staff are trained to use emergency kit. And training now includes oxygen equipment, following lessons learned from an adverse incident.

Patient care

According to the medical records we examined, custody nurses see most detainees within a few minutes of referral. However, referrals are often made verbally and not recorded on the custody record. The health team manager is working on producing a guide to remind custody staff of the important information they must write on the custody record.

Nurses meet the privacy and dignity needs of detainees well in the medical rooms, and are courteous and respectful. However, we observed nurses at custody desks when detainees were booked in. Some nurses occasionally questioned detainees during the custody officer's risk assessments. These questions and responses were audible to arresting officers and other detainees being booked in close by, which compromised confidentiality.

The presence of custody nurses at the custody desk is potentially confusing for detainees as they could be perceived as custody detention officers. The nurses' role also becomes blurred when they help with some routine custody duties, such as chaperoning female detainees. While well intentioned and reflecting team working, professional boundaries are stretched by these activities. The health manager told us they would address these concerns.

Nurses' practices are evidence based. For example, they use standard assessments for head injuries or alcohol intoxication to support clinical decision making. Medicine management arrangements are very good, although nurses don't have access to NHS Spine to check patients' current medicines. (NHS Spine is an online system that allows patients' medical information to be shared with other health professionals when needed.) Nurses administer medicines to patients using patient group directions and occasionally speak with forensic medical examiners from MHC, to discuss patients with more complex needs.

Some custody records contain entries from custody nurses that are full of information. As this information may be seen by solicitors or independent custody visitors, there is a risk of inadvertently sharing confidential medical information with third parties. The health manager reviewed this during our inspection. They have since begun to make sure that nurses' entries in custody records are helpful, while not compromising confidentiality.

Area for improvement

Standards for professional relationships and custody record keeping should be checked by regular clinical audit to assure compliance.

Substance misuse

The force works well with other organisations to care for drug and alcohol users in custody and the wider criminal justice system. This includes:

- the OPCC;
- local authorities and probation; and
- non-governmental groups such as the Kaleidoscope Project.

Overall, the approach in North Wales is very good.

Detainees with low-risk drug offences can be referred to the Checkpoint service before, and in, custody. If they take part in a drug education programme, any prosecution will be deferred. Initial evaluation of the service suggests that repeat offending has reduced.

Detainees in custody with drug and alcohol problems can be referred to Dechrau Newydd. This is a multi-agency pan-North Wales drug service. Dechrau Newydd workers phone the custody suite each weekday to identify detainees in urgent need. They then visit custody suites to talk to, and help, detainees.

Detainees experiencing withdrawal from alcohol and substances have access to symptomatic relief. This is administered by custody nurses. Opiate substitution therapy is not available, contrary to national guidance (it is not required under the health care contract). The force started providing OST following our 2014 inspection. But this stopped when MHC was commissioned to provide the service. This is a poor outcome for detainees as can be seen from the two cases described below.

During our inspection, two patients with community-prescribed methadone in their possession were prevented from taking it at their usual times. In one case, this led to prescribing for withdrawal effects, which could have been avoided if OST was available. In the other case, it led to challenging behaviour from the detainee due to frustration. Nurses said that the unavailability of OST, causing detainees to begin withdrawal, happened two or three times a week. This is unacceptable.

Nicotine replacement products are not available to detainees in custody, despite being introduced after our last inspection. This is due to MHC policy. However, if detainees have these products with them, or someone brings them into custody for them, they can be issued.

Naloxone (used to counter the effects of opiate overdose) by injection and by nasal spray is in emergency bags in the custody suites. Detainees engaging with Dechrau Newydd are offered training to use naloxone and supplies to use at home, in case of collapse. Needle exchange for high-risk substance misusers isn't available in custody. But supplies can be obtained from organisations Dechrau Newydd works with.

Area for improvement

Detainees should be able to access opiate substitution therapy and nicotine replacement products while in custody.

Mental health

Patients with mental health needs get good support in the custody suites. Custody officers and nurses receive enhanced training on mental health issues. This means that custody officers know when to refer detainees to nurses for assessment.

The Criminal Justice Liaison Service (CJLS) from Betsi Cadwaladr University Health Board is effective and appreciated by the force. The role of the CJLS is to divert detainees from police custody and court in North Wales. Although there is no constant presence, their staff visit the custody suites at Llay and St Asaph. At Caernarfon, they phone to receive referrals and interact with detainees as necessary.

A CJLS mental health nurse works in the control room from 11.00am to midnight each day. The nurse gives advice over the phone to officers on the street. They also speak to detainees and advise officers on potential options for diversion from custody. When the nurse is involved, section 136 detentions under section 136 of the Mental Health Act 1983 are often avoided. The force meets with mental health services and is considering how to achieve more diversions from custody and avoid section 136 detentions.

Where custody nurses have concerns about a detainee's mental health, they ask officers to take the detainee directly to the designated hospital emergency departments. After initial triage, detainees can then be assessed by the mental health professionals at the hospital. We were told this happened promptly. Depending on the result of the assessment, the detainee would either enter hospital for treatment or return to custody for the investigation into their case to continue. Custody nurses told us that this sometimes left them dealing with detainees who may not need detention under the Mental Health Act but still showed signs of mental distress.

We were told that Mental Health Act assessments in custody could also be arranged promptly. But we were also told that, at times, detainees have been detained under section 136 in custody. This is so they can be taken to the hospital or health-based place of safety for a Mental Health Act assessment. The reasons for this are not entirely clear and the force needs to monitor and understand when and why this happens.

The force often transfers detainees to hospital using its own transport. This is because the ambulance service has limited capacity to respond promptly.

Section 5. Release and transfer from custody

Expected outcomes

Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

The force has a clear focus on ensuring detainees are released safely. We saw some good attention and care given to detainees on release.

Custody officers interact well with detainees to complete pre-release risk assessments. They use initial risk assessments and care plans appropriately so that any risks identified are addressed or mitigated before detainees are released. Where there are concerns, custody officers refer detainees to the custody nurse for a fitness to release assessment. This is to make sure that detainees' needs are assessed and met where possible before release. Also, where necessary, relevant organisations are involved to support the release. However, some custody records don't include enough detail (for example, on how a detainee is getting home after release).

Detainees who don't have the means to get home safely can make telephone calls to arrange transport. They can also access bus tickets and accounts with local taxi firms (although this isn't the case at Caernarfon as these services aren't available from the local bus operators and taxi firms). This is paid for by the police if needed. Police officers take children and vulnerable adults home when it is not possible to release them into the care of a responsible adult.

Leaflets containing information about both national and local support organisations are available. These are given to all detainees on release, but not to those transferring to court. However, this leaflet is only available in English and Welsh.

Most custody officers are aware of the enhanced safeguarding arrangements for those arrested under suspicion of committing serious sexual offences. They told us that there is a good exchange of information from interviewing officers. They use this information when completing the pre-release risk assessment. Some custody officers also had access to a specialist support leaflet to give to detainees in these cases.

Custody detention officers complete digital person escort records (dPERs) to provide information about the detainee and any risks for the escorting agency. They also book transport for detainees attending court or who have been recalled to prison. These are completed well, and custody officers check and sign them off. However, custody officers don't complete any pre-release risk assessments with detainees transferring to court. This means that potential risks may not be addressed or mitigated before transfer.

When a detainee is transferred to hospital for medical attention, custody staff prepare a paper person escort record (PER) for escorting staff. This identifies risks and warning markers, but is often poorly completed. The failure to record relevant information doesn't meet the requirements of APP guidance.

Areas for improvement

The force should make sure that:

- custody officers engage with detainees transferred to court, to identify and mitigate risks before their transfer from police custody; and
- paper person escort records are fully completed for detainees transferring to hospital, in line with APP guidance.

Courts

Ways of working between the force and HM Courts and Tribunals Service (HMCTS) make sure that once detainees are remanded, they are generally presented before the first available court. This has improved since our last inspection and means that most detainees are held for no longer than necessary.

Detainees remanded for court are generally collected promptly in the morning. Those arrested on warrant during the day can be taken directly to the local magistrates' courts. This is providing there is cell space available and the court has the capacity to deal with them. This is a good outcome for the detainee as it keeps the time they are held in police custody to a minimum.

Temporary video link arrangements are available in the custody suites to hear cases virtually if required. These are used if a detainee is suspected of or confirmed as having COVID-19 and avoids any unnecessary need to travel. This manages and minimises the risk of infection transmission.

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

Causes of concern and recommendations

Cause of concern: Meeting legal requirements and guidance

The force doesn't always comply with the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. There are several areas where the requirements aren't always met. These include:

- those relating to the necessity for, and the circumstances of, arrest;
- providing detainees with written copies of their rights and entitlements;
- reviews of detention; and
- custody officers directing investigations.

Recommendation

The force should take immediate action to make sure that all custody procedures and practices comply with legislation and guidance.

Cause of concern: Use of force

North Wales Police's governance and oversight of the use of force in custody are limited. Information on what force is used, by which officers, or why it is necessary is often incomplete or inaccurate. It is often used to forcibly remove clothing with little justification shown or evident. There are few reviews of incidents on CCTV to assess how well they are handled or whether the force used is necessary and proportionate. Our review of incidents suggests that sometimes it was not.

Recommendation

The force should scrutinise the use of force in custody. This should be based on accurate information and robust quality assurance, including viewing CCTV footage of incidents. It should use this to show that when force is used in custody, it is necessary and proportionate.

Cause of concern: Quality of custody records

The quality of recording on custody records is poor. This is because:

- important information is sometimes missing or inaccurately recorded;
- the reasons and justification for decisions isn't always clear;
- entries are often a mix of pre-populated standard text, alongside information on what had been done – making them confusing to understand; and
- quality assurance isn't effectively assessing the standard of records or identifying concerns.

This makes it difficult to establish how detainees have been treated in custody, and whether all processes have been applied correctly.

Recommendation

The force should make sure that the information recorded in custody records is accurate and complete. It should clearly reflect the individual action taken and the reasons for any decisions for each detainee. The force should robustly quality assure custody records to identify and act on any concerns.

Cause of concern: Detainee safety and risk assessment

The force is not managing detainee risks well enough because:

- Different custody detention officers carry out checks so there is often little continuity to assess changes in a detainee's demeanour.
- Rousal checks are not always conducted in the correct way or properly documented.
- Custody officers continue to routinely remove clothing with cords and footwear without an individualised risk assessment and it isn't always documented when or why clothing has been removed.
- Anti-rip clothing continues to be used frequently, often without adequate rationale. On occasions, this appears pre-emptive and in many cases is justified only because the detainee didn't answer the risk assessment questions. This is a risk averse approach, which often leads to clothing being unnecessarily and forcibly removed.
- Areas where staff carry out constant CCTV monitoring (authorised professional practice (APP) Level 3) are not covered by CCTV.
- Detainees queuing to be booked in aren't triaged to prioritise them.
- Custody staff do not maintain sufficient control and oversight of custody keys.

These practices do not follow APP guidance and potentially place detainees at significant risk of harm.

Recommendation

The force should take immediate action to mitigate the risk to detainees by making sure that its risk management practices follow APP guidance and are carried out and recorded to the required standard.

Areas for improvement

Leadership, accountability and partnerships

- The force should make sure that all custody staff follow the College of Policing's APP (Detention and Custody), as well as its own guidance. This will mean that detainees receive an appropriate and consistent level of treatment and care.
- The force should strengthen its approach to performance management by collecting and monitoring accurate information for its main services, and showing the outcomes achieved for detainees.

First point of contact

Officers should always have access to advice from mental health services to help them deal with people with mental ill health appropriately.

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

- The force should improve its approach to detainee dignity and privacy by making sure that:
    - staff communicate with detainees in a way that responds to their individual needs;
    - detainees can disclose private or sensitive information in a confidential environment, including during the initial risk assessment;
    - detainees can shower in sufficient privacy at all custody suites; and
    - detainees' clothes are respectfully removed and always stored properly.
- The force should strengthen its approach to meeting detainees' individual and diverse needs by making sure that:
    - there is suitable provision for those with disabilities at all suites;
    - all detainees are asked to identify their ethnicity;
    - a female member of staff is readily available when assigned for female detainees, and carries out the role effectively; and
    - there is an adequate supply of resources for the main religious faiths at all suites, and they are given to those who may want them.
- Custody officers should consistently provide an easy read version of rights and entitlements to children, vulnerable adults and other detainees who would benefit from them.
- Detainees should be able to make a complaint easily, and before they leave custody.

In the custody cell, safeguarding and health care

- Notices advising that CCTV is in operation should be prominently displayed throughout the suites.
- The force should adhere to legal requirements for fire regulations, particularly around emergency evacuations. Appropriate fire exit signs should be displayed at St Asaph.
- Detainees should receive appropriate aftercare when sprayed with incapacitant.
- Handcuffs should be removed from compliant detainees at the earliest opportunity.
- The force should improve its care for detainees by making sure:
    - detainees are offered the range of available services, including books, distraction materials, food, exercise or a shower; and
    - a good range of food is always available.
- The force should strengthen its approach to AAs by making sure that:
    - all vulnerable adults in custody receive an AA; and
    - all children and vulnerable adults in custody are supported quickly, and information is collected to assess this.
- The force should continue to work with local authorities to improve the provision of alternative accommodation for children who are charged and refused bail.
- Standards for professional relationships and custody record keeping should be checked by regular clinical audit to assure compliance.
- Detainees should be able to access opiate substitution therapy and nicotine replacement products while in custody.

Release and transfer from custody

The force should make sure that:

- custody officers engage with detainees transferred to court, to identify and mitigate risks before their transfer from police custody; and
- paper person escort records are fully completed for detainees transferring to hospital, in line with APP guidance.

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 through their time in custody to their release. Our inspections are unannounced, and we visit the force over a two-week period. 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;
- demographic information;
- the number of voluntary attendees;
- the average time in detention;

- children; and
- detainees with mental ill health.

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

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection in all the suites in the force area. Records analysed are chosen at random. And a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week. This has a 95 percent confidence interval with a sampling error of 7 percent. The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.

A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can be assumed to represent a real difference between the two populations. To appropriately adjust p-values in light of multiple testing, $p<0.01$ was considered statistically significant for all comparisons carried out. This means there is only a one percent likelihood that the difference is due to chance.

Case audits

We carry out in-depth audits of approximately 40 case records (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, vulnerable people, individuals with mental ill health, and where force has been used on a detainee.

The audits examine a range of factors to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing detainees' physical condition, and observing operational practices and how detainees are dealt with and treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first-hand. We also speak with 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 the way in which detainees are dealt with, and whether policies and procedures are followed.

Interviews with staff

During the inspection we carry out interviews with 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 with 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. Following this, a report is published 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 approximately one year after our inspection to assess progress against our recommendations.

Appendix II: Inspection team

- Norma Collicott: HMI Constabulary and Fire & Rescue Services inspection lead
- Anthony Davies: HMI Constabulary and Fire & Rescue Services inspection officer
- Patricia Nixon: HMI Constabulary and Fire & Rescue Services inspection officer
- Ramzan Mohyiuddin: HMI Constabulary and Fire & Rescue Services inspection officer
- Sutinderjit Mahil: HMI Constabulary and Fire & Rescue Services inspection officer
- Andy Reed: HMI Constabulary and Fire & Rescue Services inspection officer
- Viv Cutbill: HMI Constabulary and Fire & Rescue Services inspection officer
- Kellie Reeve: HMI Prisons team leader
- Fiona Shearlaw: HMI Prisons inspector
- Martin Kettle: HMI Prisons inspector
- Paul Tarbuck HMI Prisons Health & Social Care inspector
- Joe Simmonds: HMI Prisons researcher
- Alec Martin: HMI Prisons researcher

www.justiceinspectorates.gov.uk/hmicfrs
www.justiceinspectorates.gov.uk/hmiprisons