



Custody Detention Scrutiny Panel Meeting Minutes

Date of Meeting	Tuesday 28 th April 2026
Time of Meeting	1:00pm-3:00pm
Location	Force HQ
PCC Contact Officer	Ms. Phoebe Stott
Constabulary Contact Officer	Head of Criminal Justice & Custody
Attendees	OPCC - Ms. P Stott OPCC - Ms. M Poole Derbyshire Constabulary – EB Derbyshire Constabulary – ND Derbyshire Constabulary – MH Spokesperson - JR Panel Member - LK Panel Member - AG Panel Member - CS

1. Welcome & Apologies

PS welcomed everyone to the meeting, and a brief round of introductions was done. PS also gave apologies for panel members PP and CB who were unable to attend.

Prior to the meeting beginning, ND gave the panel members an update on the progress of the new Chesterfield Custody Suit that is being built.



2. Declarations of Interest

PS asked if anyone had any declarations of interest before the meeting began - no panel members declared anything. PS explained that if during the meeting anyone realised that they did have any, then they should let her know.

3. Minutes of Previous Meeting

PS explained that reviewing the previous meeting's minutes during this session was challenging, as the current panel did not attend the last meeting due to the rotation system in place. Since the panels alternate attendance, the minutes were not directly applicable for discussion.

However, PS noted that all panel members receive copies of the minutes from every meeting, regardless of attendance, to ensure everyone stays informed. She therefore invited any comments or questions.

The panel confirmed they had no concerns or questions to raise.

4. Review of Actions

PS informed the panel that all the actions from the previous meeting have been completed and the action log has been uploaded to the website.

SCRUTINY: Mental Health

Prior to the meeting, JR sent PS her pre-meet report in which contained and collated all the panel members' feedback in relation to the custody records and data ahead of the meeting.

For the purpose of the minutes, all custody records for each topic were reviewed first then followed by a discussion regarding the data provided.

5. Custody Records

CXXXXX305

Age:	50
Ethnicity:	White British
Gender:	Male
Suite:	Ripley
Length of Detention:	21 hours 57 minutes
Panel Comments:	The Panel considered the detention of a detainee presenting with known mental health (MH) vulnerabilities, including expressions of suicidal ideation and self-harm, alongside a history of MH concerns and use of force prior to arrival in custody. Whilst the Panel were satisfied that appropriate observation levels (Level 3 with 30-minute checks) were implemented and largely adhered to, concerns were raised regarding the timing and sequencing of key safeguards. In particular, the detainee was interviewed before being assessed by a Health Care Professional (HCP), with the HCP review taking place approximately 20 hours after arrest. The subsequent assessment determined the detainee was unfit for interview and continued detention due to their MH presentation, which raised concern about the delay in clinical oversight and the appropriateness of proceeding with interview beforehand. The Panel also queried whether delays in access to an Approved Mental Health Practitioner (AMHP) are a recurring issue, particularly overnight, and whether the detainee's location impacts the timeliness of such assessments. It was noted positively that, once concerns were identified, appropriate action was taken to transfer the detainee to hospital for a MH Act Assessment in line with the standard operating procedure SOP. However, the Panel identified a gap in recording, specifically the absence of a clear Niche entry confirming that escorting officers had been briefed with

	relevant information to pass to medical staff. A further minor concern was raised regarding a likely data entry error suggesting an incorrect time gap between arrest and arrival in custody. During the detainee's second period of detention, their presentation was notably less concerning, risk was appropriately reassessed, and proportionate observation levels were applied, with the detention passing without incident. Overall, whilst the Panel were satisfied that day-to-day care and observation levels were appropriate, the key concerns relate to the delay in HCP assessment, the timing of the interview in relation to that assessment, and the need for improved accuracy and completeness in recording.
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MH advised that the detainee came into custody under the influence of drugs and/or alcohol and as such it is likely that the extent of their mental health concerns was not fully identifiable at the point of booking in. These concerns appear to have become more evident at a later stage, potentially during consultation with the detainee's solicitor prior to interview.

ND explained that this can be a common occurrence within custody settings, as custody officers are limited in the nature of questions they can ask detainees. In line with PACE, officers are unable to explore details relating to the offence or the circumstances leading to arrest, as this could constitute an unrecorded interview. Instead, custody staff are restricted to asking general welfare-based questions, for example "How are you?" and ensuring ongoing care through regular checks, provision of food and drink, and monitoring presentation. Whilst these interactions may highlight welfare concerns, they may not fully reveal underlying mental health issues, and these may only become apparent when the detainee discusses the alleged offence in a formal, recorded setting.

It was therefore indicated that the detainee's mental health presentation became clearer at the point of legal consultation, which subsequently prompted a request for a fitness to

interview assessment. Based on the information available, it appears that the detainee may not have proceeded to interview once these concerns had been identified.

In relation to the delay in mental health assessment, ND explained that Approved Mental Health Practitioner (AMHPs) operate on an on-call basis across the entire county and are often based within mental health units. As a result, their availability can be impacted by competing demands, which may lead to delays in attendance at custody suites. ND outlined that the preferred approach is to transfer detainees to an approved place of safety for assessment, with AMHPs only attending custody environments in limited circumstances, such as where a detainee presents a significant risk, which was noted as occurring infrequently.

Force also clarified that, in this instance, the detainee was effectively released from custody to attend hospital for a Mental Health Act assessment, and subsequently returned to custody thereafter, which accounts for the sequence of events recorded.

CXXXXX554

Age:	13
Ethnicity:	Black African including Black British
Gender:	Female
Suite:	Derby
Length of Detention:	8 hours 57 minutes
Panel Comments:	The Panel reviewed the detention of a juvenile detainee with significant and complex mental health needs, including a history of self-harm, depression, anxiety and psychosis, and who disclosed active thoughts of self-harm on arrival. Initial concerns were raised regarding an apparent delay of 1 hour and 12 minutes before authorised detention, attributed to staff managing other detainees. However, this appeared inconsistent with an earlier entry indicating that booking-in processes had been prioritised, including contact with Social Care, provision of Easy-Read rights, and referral to a Health Care Professional (HCP). The Panel sought clarification on these conflicting records.

The detainee was appropriately placed on Level 4 constant observations, reflecting her high level of risk, and initial allocation of a female officer was noted. However, the Panel were concerned that there was no clear record of this being maintained following shift handover. Whilst there was evidence of multi-agency engagement, including timely involvement of the CJLDT team and liaison with CAMHS services, the Panel noted some inconsistency in the detainee's clinical presentation. Despite being deemed fit to detain following an HCP assessment, her condition appeared to deteriorate later in the evening, resulting in her being assessed as fit to detain but unfit for interview, charge, or transfer, with further mental health assessment recommended.

The Panel highlighted the complexity of decision-making in this case, particularly regarding the use of Section 136 powers, where conflicting advice was received. Mental health triage suggested use of S136, whereas the AMHP advised against this due to the detainee's age. The Panel commended a detailed entry from the Custody Sergeant outlining the challenges faced; however, raised concern that attempts to access relevant standard operating procedures (SOPs) were unsuccessful, and requested clarification from Force on access to policy in such critical situations.

Further queries were raised regarding the decision-making and subsequent events relating to the detainee's removal from custody. The record refers to transfer to "the Bungalow within the police station grounds" and potential further liaison with Social Care or use of S136 powers. The Panel were unable to identify this facility and requested clarification on what this location is, and what ultimately occurred following the detainee's departure from custody, including how such pathways operate in practice.

Whilst the Panel recognised that custody staff made considerable efforts to care for the detainee in challenging

	circumstances, including provision of reading material and attention to her needs, concerns were raised regarding the timing and recording of key events. In particular, the detainee was interviewed in the presence of a solicitor, but there was no clear record of an Appropriate Adult (AA) being present, and shortly afterwards she was deemed unfit for interview by the HCP. The Panel therefore questioned the appropriateness of the interview and requested clarification on the sequence of events and decision-making. Finally, the Panel noted a curious and unclear entry within the custody record relating to an “override time detention,” which lacked sufficient explanation and raised concerns about accuracy and clarity in recording. Overall, whilst the Panel acknowledged the efforts made by custody staff and the complexities of managing a high-risk juvenile detainee, key concerns centre on recording inconsistencies, access to guidance, clarity of decision-making, and the appropriateness and sequencing of key safeguards, particularly in relation to interview and mental health assessment.
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With regards to the hour and 12-minute waiting time between arrival and authorised detention, MH confirmed nationally this is not a long time for anyone. He explained that when booking in a juvenile, the suite has to be cleared and if someone is already getting booked in this must continue. Additionally, if people are waiting to be bailed they have to be completed and cleared. MH confirmed that although this time was a slightly longer than they would like, there are no causes for concern.

MH acknowledged that a female officer should have been allocated to the detainee after handover given her risk level and vulnerability; however, it is believed this may have been affected by an entry on the detainee’s custody record suggesting she was going to be released NFA at 7:30.

In relation to the SOP access issue, MH confirmed that this was due to a system error, and advised that had the issue been formally raised at the time, access could have been restored. This has been identified as a technical rather than procedural issue.

MH clarified that the reference to “the Bungalow” relates to a separate building within the police station grounds, which includes a Video-Recorded Interview (VRI) suite, and is used for alternative processes and multi-agency liaison outside of the main custody environment.

Regarding the unusual custody record entry, MH was unable to provide a definitive explanation but suggested that it appears to relate to an override of the custody detention clock, potentially linked to a breach of bail calculation. Further detail was not available.

SCRUTINY: Use of Anti-Rip / Safety Suits

6. Custody Records

CXXXXX566

Age:	49
Ethnicity:	White British
Gender:	Female
Suite:	Ripley
Length of Detention:	1 day, 18 hours, 4 minutes
Panel Comments:	The Panel reviewed what was recognised as an extremely challenging detention, involving a detainee with multiple health issues, including significant mental health concerns, a history of self-harm, and violence towards others. The detainee was placed on Level 4 constant observations, at times requiring two officers, and was assessed by both the HCP and Liaison and Diversion (L&D) services shortly after arrival. During the period between authorised detention and the eventual issue of an anti-rip/safety suit (ARS), the detainee displayed highly distressed and complex behaviours, including repeated nudity,

soiling within the cell, and ongoing self-harm risks. Use of force was applied on more than one occasion and was considered by the Panel to be well justified and proportionate in response to the risks presented.

The introduction of the ARS followed multiple incidents of self-harming behaviour, including an attempt to use clothing as a ligature whilst on constant observations. The Panel agreed that the decision to implement the ARS at this stage was appropriate and necessary, particularly as it reduced the need for continued physical restraint. Whilst acknowledging the ICVA position that ARS should not be used, the Panel did not consider its use in this instance to be punitive or excessive, given the detainee's sustained and high-risk behaviour. However, the Panel queried whether any alternative measures could have been considered, particularly as even elements of the suit (such as the tunic) were deemed a risk when not worn as intended, and whether the ARS ultimately achieved its intended purpose.

The Panel also identified gaps in recording, particularly in relation to the management and review of the ARS. Whilst the SOP requires review every three hours, including at handovers and during formal reviews, the custody record did not consistently reflect that these reviews had taken place or that continued use had been explicitly justified. Although the Panel did not consider the ongoing use of the ARS to be inappropriate in light of the detainee's behaviour, they noted that documentation did not fully evidence decision-making, which may present issues under scrutiny or inspection.

Further concerns were raised regarding the lack of clarity around removal of the ARS and the detainee's clothing upon transfer to court, with only a general reference to the detainee being "dressed" and no clear record of when the ARS was removed.

	Overall, the Panel felt that this detainee presented with highly complex and distressing needs, requiring significant resources and careful management, and that custody staff appeared to provide care as effectively as possible under the circumstances. However, key concerns relate to recording, review processes, and clarity of decision-making, particularly in relation to the use and ongoing management of ARS.
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ND and MH confirmed that the terms anti-rip suit, safety suit, and safety clothing refer to the same equipment. In response to whether alternative measures could have been considered, ND advised that, given the detainee's continued high-risk behaviour, there were no more suitable alternatives available, and staff were required to use the most effective tools at their disposal to manage risk. It was recognised that, in such cases, it is not always possible to completely eliminate risk.

In relation to the review of ARS usage, ND acknowledged that reviews should have been more clearly documented in line with SOP requirements. However, it was highlighted that the detainee's ongoing presentation and behaviour, as recorded throughout the detention, would have consistently supported the continued use of the ARS, and it is likely that any formal reviews undertaken would have reached the same conclusion.

CXXXXX645

Age:	27
Ethnicity:	White British
Gender:	Indeterminate Sex
Suite:	Derby
Length of Detention:	2 days, 7 hours, 6 minutes
Panel Comments:	The Panel reviewed the detention of a detainee identified as indeterminate sex, noting overall that documentation regarding gender identity was handled well, with a clear entry confirming the detainee identified as male and had appropriately requested a male officer for searching. The detention itself was recognised as highly challenging, involving a detainee with autism, substance use, and a history of self-harm and suicidal

	behaviour. An Appropriate Adult (AA) was correctly identified, and observation levels were appropriately escalated from Level 3 to Level 4 constant observations following a clear episode of self-harming behaviour shortly after arrival. The Panel noted multiple instances of use of force across the detention, including handcuffs and, at times, leg restraints, in response to repeated attempts by the detainee to self-harm, including using clothing as a ligature. These interventions appeared to be regularly reviewed and adjusted in response to the detainee's presentation, with restraints removed when behaviour settled and reapplied when risk escalated. However, some inconsistencies in recording were identified, particularly concerning when restraints were removed, as subsequent entries did not always clearly account for this. The Panel also noted one entry highlighting the incorrect application of handcuffs, demonstrating oversight but also reinforcing the need for accurate recording. The decision to implement a safety suit (anti-rip suit) was made later in the detention following continued self-harm attempts. While the Panel agreed that the eventual use of the safety suit was appropriate and necessary, given the detainee's repeated attempts to use clothing as a ligature, questions were raised regarding the timing of its introduction. Specifically, the Panel queried whether earlier use of the suit may have reduced the need for repeated use of force and mitigated further self-harm attempts, although it was acknowledged that this was a prolonged detention and that decision-making may have been influenced by the expectation of continued custody due to mental health concerns. The Panel noted that once the safety suit was in place, there were some recorded reviews of its use, including overnight; however, as in the previous case, opportunities were missed to document reviews at key points, particularly at handover. This was identified as a recurring issue, where practice may
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	have been appropriate but was not consistently evidenced through recording in line with SOP requirements. Overall, the Panel considered that the detainee's risks were managed with ongoing attention and adaptability in a complex situation, and that the use of the safety suit was justified. However, key concerns remain regarding the timing of interventions, clarity and continuity of recording (particularly around use of force and restraint), and consistent documentation of safety suit reviews.
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ND acknowledged the entry relating to the incorrect application of handcuffs, noting that whilst the technique used was not ideal, it is still a permissible method within training parameters and, importantly, did not result in any injury to the detainee.

In relation to the removal and review of restraints, Force confirmed that both the removal of restraints and any decision to continue their use should be clearly recorded within the custody record, and this was identified as an area where recording could be improved.

Regarding the timing of the safety suit (anti-rip suit), ND advised that its use is always a balanced and dynamic judgement, based on risk at the time. It was acknowledged that earlier use of the suit could have been justified in this case; however, it was emphasised that the use of a safety suit does not eliminate all risk, as detainees may still attempt self-harm through other means. ND also highlighted that the anticipated transfer to court may have contributed to an increase in the detainee's distress and risk level, as they may have been anxious about the possibility of remand or sentencing, which would have influenced decision-making throughout the detention.

SCRUTINY: Access to Services

7. Custody Records

CXXXXX150

Age:	13
Ethnicity:	Any other mixed
Gender:	Male
Suite:	Ripley
Length of Detention:	Total 22 hours 42 minutes - but see comments below
HCP Comments:	The detainee was assessed at booking in and was considered not to require a Health Care Professional (HCP) assessment at that time. The Panel noted this decision without raising specific concerns, although it was considered alongside the detainee's overall needs as a juvenile.
AA Comments:	The requirement for an Appropriate Adult was correctly identified at the point of detention, and the detainee received timely support, with the AA present for risk assessment, rights, and sample procedures shortly after arrival. However, the Panel raised concern that there was no clear record of the AA being present during interview or at the point of release, which represents a significant gap in documentation for a juvenile detainee.
Solicitor Comments:	Consultation with a solicitor was recorded within a reasonable timeframe. However, the Panel noted poor recording of the interview itself, with no clear documentation of who was present. Whilst it was likely that the solicitor attended, given the prior consultation, this was not explicitly confirmed and therefore lacked evidential clarity.
L&D Comments:	Given the detainee's status as a juvenile, the Panel felt this case should have been prioritised for L&D screening and in-person engagement. The only reference to L&D involvement was a brief note within the pre-release risk assessment indicating that a leaflet had been offered and screening undertaken. The Panel acknowledged that the detainee's

	short time in custody (just over three hours) may have limited L&D involvement, but still highlighted this as an area for consideration.
Interpreter Comments:	Interpreter services were not applicable in this case.
General Comments:	The Panel noted that Social Care had been informed promptly, and a juvenile pre-release risk assessment was completed. However, concerns were raised regarding clarity of release times, as it appeared that a system issue resulted in the custody record being placed in an "admin cell," making it unclear exactly when the detainee was released. The Panel felt the record should clearly reflect the actual time of release once resolved. Additionally, the Panel raised concern that the escorting officer failed to activate body-worn video (BWV) when bringing the detainee into custody. Although it was suggested this may have been due to the detainee arriving under street bail rather than arrest, the Panel considered this poor practice, as it could have led to a lack of evidence had any incident or allegation arisen at that point, and requested Force comment.

ND advised that, whilst best practice would be to refer all juvenile detainees to a HCP, referrals are clinically prioritised, and in the absence of an identified medical need, attendance may not be immediate. Similarly, ND confirmed that juveniles are considered a priority cohort for Liaison and Diversion (L&D) services, alongside other identified groups. However, engagement from L&D remains dependent on availability and referral processes, particularly in cases where detention periods are relatively short.

In relation to the presence of an Appropriate Adult (AA), EB confirmed that the AA was present at both interview and release, but their details had been redacted from the custody record, which resulted in the appearance that no one was present.

ND acknowledged that the recording of attendees at interview remains a recurring issue, with officers not always notifying custody staff when an interview takes place following solicitor consultation. Measures have been introduced to mitigate this, including

expectations for custody staff to update records upon return from interview, although this is not consistently applied. It was confirmed that, in this case, both the solicitor and AA were present, and further feedback will be provided to reinforce recording standards. ND recognised the Panel's ongoing concern in this area and advised that, whilst inconsistencies remain, internal scrutiny and dip-sampling indicate an overall improving trend in recording practices.

ND also acknowledged concerns regarding the clarity of release times, explaining that multiple custody staff involvement may have contributed to gaps in recording. However, associated entries, including bail, pre-release risk assessment and biometric processes, indicate that the detainee would have been released shortly after these actions, with formal release recorded at 16:11hrs when bail was granted.

Regarding the use of body-worn video (BWV), ND confirmed that officers are expected to activate BWV when arresting or transporting detainees; however, this responsibility rests with the arresting or escorting officers rather than custody staff. It was further clarified that, in this instance, the detainee was arrested at the custody suite upon attending for bail, and therefore only required to be escorted within the building, which is likely why BWV was not activated.

CXXXXX050

Age:	25
Ethnicity:	White Roma
Gender:	Male
Suite:	Derby
Length of Detention:	1 day, 13 hours, 27 minutes
HCP Comments:	No specific concerns were raised by the Panel in relation to Health Care Professional (HCP) involvement beyond those captured elsewhere in the record.
AA Comments:	The detainee was correctly assessed as not requiring an Appropriate Adult, and the Panel agreed with this decision.
Solicitor Comments:	The detainee had a consultation with a solicitor prior to interview, and it was clearly recorded that both the solicitor

	and interpreter were present during the interview, which the Panel considered to be appropriate and well documented.
L&D Comments:	There was no requirement for Liaison and Diversion involvement, and the Panel agreed with this assessment.
Interpreter Comments:	The Panel gave detailed consideration to the use of interpreter services. At booking in, it was recorded that the detainee could read and write only in Romanian but was assessed as not requiring an interpreter at that stage. Whilst it appeared the detainee had some understanding of spoken English, the Panel identified that there was no record of written rights or documentation being provided in Romanian, which is a concern given his limited literacy in English. The Panel noted positively that an interpreter was used during the HCP consultation for drug/drive bloods, which was considered good practice, particularly given the invasive nature of the procedure and potential implications. Following this, the detainee's needs were reassessed, and it was recorded that a Romanian interpreter was required. An interpreter was subsequently present for interview; however, there was no record of an interpreter being present during earlier procedures, such as samples. The Panel further noted a significant delay in rights being reissued with an interpreter, with rights initially provided without one and then not repeated with interpreter support until nearly 18 hours later and after the interview had taken place. While it was acknowledged that custody staff were awaiting interpreter availability, this did not appear to significantly delay the overall process, and an interpreter was appropriately arranged for the detainee's court appearance.
General Comments:	The Panel noted a delay of 2 hours and 33 minutes between arrival and authorised detention, attributed to backlog during custody handover. The detainee was issued with an IM3 notice due to overstaying a visa, though the outcome of this was not known.

	Overall, the Panel felt the detainee was provided with appropriate services, with particular positive recognition of interpreter use during the HCP consultation. However, concern remains regarding the lack of written information in the detainee's native language and delays in fully implementing interpreter support, particularly given that Romanian interpreter demand is known to be high. The Panel suggested that written materials in commonly required languages should be readily available within custody suites.
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ND confirmed that written information in Romanian is available, both through the Niche system (including Annex M) and via the Gov.uk website, which is accessible to custody staff. It was emphasised that this is not an issue of availability, but rather a matter of recording, as there was no clear documentation confirming whether these materials were provided. MH advised that if the detainee had required written information, it would have been supplied, and therefore the issue relates to the lack of recorded evidence rather than a failure in provision.

8. All topics - Figures and Statistics

General Data

The Panel reviewed custody data for the period 1st December 2025 to 28th February 2026, alongside comparative data from previous periods. The inclusion of Derbyshire demographic data from the 2021 Census was welcomed, as it provided useful contextual background, despite now being several years old.

Overall custody numbers increased by approximately 5% compared to the same period the previous year, although figures from the preceding three-month period had shown a slight decrease. While seasonal factors such as the Christmas and New Year period may have influenced this increase, comparisons with the previous year suggest this trend cannot be attributed solely to the festive period. Over a three-year period, the data

indicates only a very slight upward trend in custody arrivals, which may not be statistically significant.

In terms of demographics, the data continues to show a disproportionately higher number of male detainees, consistent with national trends. The Panel also noted an over-representation of Black and Asian detainees compared to the general population. Although there has been a slight reduction during the current period compared to the previous year, this change is minimal across the three-year overview. The Panel queried whether this reflects national patterns and whether further detailed analysis would be beneficial.

General Data – Force Response

EB acknowledged that the data does indicate some level of disproportionality in those arriving in custody. However, it was emphasised that this is not a function of custody processes, as custody staff have no influence over who is brought into custody, and therefore this sits outside the direct remit of custody operations.

It was also noted that the Census data reflects Derbyshire residents only, whereas individuals brought into custody may originate from outside the county, particularly given Derbyshire's proximity to neighbouring force areas. This limits the direct comparability of the datasets.

For reassurance, EB advised that issues relating to disproportionality are considered at a strategic level by the Force Disproportionality Board, which reviews data and trends in greater detail. National data was also referenced, suggesting that Derbyshire broadly aligns with national figures in terms of ethnic representation within custody.

Children in Custody

The data highlights a significant and increasing disproportion of male children in custody, with males accounting for over 90% of juvenile detainees during the review period.



Encouragingly, there has been a substantial reduction (approximately 30%) in the number of children detained, compared to the same period the previous year. The Panel queried whether this reflects a sustained trend and whether it may be influenced by the greater use of alternative pathways for young offenders.

However, it was noted that the number of Black children detained remained consistent, resulting in an increased proportional representation compared to their peers. The Panel recognised that multiple factors may contribute to this, including repeat offending or wider demographic changes, and requested further insight into this trend.

Children in Custody – Force Response

EB highlighted that there has been ongoing and significant work to reduce the number of children entering custody, and where detention is necessary, to ensure that time spent in custody is minimised. The reduction seen in the data is viewed positively and reflects the use of alternative approaches, including out-of-court disposals and deferred prosecutions.

In relation to the representation of Black children in custody, EB provided further breakdown data indicating that the majority of cases represent first-time arrivals, with only a small number relating to repeat attendances linked to bail or voluntary attendance. Analysis suggests that the figures involve a relatively small number of individuals, with some repeat cases influencing overall representation.

EB also noted that further work is being undertaken with Youth Justice Services to better understand trends relating to young people, including any underlying factors that may explain variations in the data over time.

Crime Type Data

The Panel noted a significant increase in cases relating to possession of weapons, compared to the same period in the previous year, and queried whether this reflects trends in knife crime. Additionally, there were a small number of homicide-related detentions in the previous year's data. While acknowledging that conclusions cannot be

drawn from these figures alone, the Panel requested further contextual information to better understand these trends.

Crime Type Data – Force Response

EB advised that crime type data is not directly relevant to the remit of the CDSP, as the panel's focus is on the treatment and management of detainees rather than the nature of alleged offences.

It was suggested that crime type may have some relevance when considering factors such as length of detention, but wider analysis of offending patterns falls outside the scope of this meeting. Whilst acknowledging the Panel's interest, EB indicated this is not an area routinely examined within custody scrutiny.

Access to Services – Data and Findings

The Panel reviewed data relating to access to services within custody.

Interpreter usage showed a 20% increase in attendance compared to the previous period, although overall numbers remain relatively low in proportion to total detainees (approximately 2.5%). The Panel noted that these figures likely reflect face-to-face interpreter use only, and may not include instances where interpreters were required but unavailable, or where telephone interpreting services were used. Additional data in this area would support a more complete understanding of service provision.

Of particular concern was the increase in cases where an AA was deemed necessary but did not attend, rising from approximately 33% to over 41%. This suggests a potential decline in service delivery for vulnerable detainees, and the Panel requested further explanation and insight into this trend.

Access to Services – Force Response

In relation to requests for more detailed data on access to services, such as interpreter provision where attendance did not occur, EB advised that this level of insight would require reviewing individual custody records, which is not currently feasible at scale.

In relation to the increase in cases where an AA was recorded as being required but not attending, ND advised that this may initially appear as a decline in service provision, but can often be attributed to improved identification and recording of vulnerability. For example, individuals with conditions such as ADHD may be categorised as vulnerable under PACE, which can trigger an initial requirement for an AA; however, this does not necessarily mean an AA is ultimately required in every case.

MH confirmed that custody staff have improved in both identifying vulnerabilities and applying professional judgement when determining whether the presence of an AA is necessary. This includes clearer justification where an AA is not deemed required following assessment.

It was also noted that there has been an increase in instances where Custody Sergeants are making proportionate decisions not to authorise detention for young people, where it is not considered necessary. In such cases, as the individual is not detained, the requirement for an AA does not arise, which may also contribute to the figures observed.

Anti-Rip / Safety Suits – Data and Findings

A total of 12 uses of anti-rip/safety suits were recorded over the reporting period, representing a very small proportion of overall detainees. No juvenile detainees required their use. The Panel noted that each instance is subject to internal scrutiny, which provides assurance around oversight.

A higher proportion of these cases involved detainees from ethnic minority backgrounds, although due to the small sample size, no firm conclusions can be drawn regarding disproportionality. The Panel recognised that each case should be considered individually and noted that no comparative historical data was available for this specific period.



Anti-Rip / Safety Suits – Force Response

No additional comments were provided in relation to the statistical overview of anti-rip/safety suit usage. However, it is noted that each individual use is subject to internal scrutiny, ensuring appropriate oversight on a case-by-case basis.

Mental Health – Data and Findings

The Panel reviewed data relating to detainees held under Section 136 of the Mental Health Act, with 28 such detentions recorded during the period. Section 136 allows police to detain individuals in public places where there are concerns regarding their mental health and safety, pending assessment.

The data shows that the gender distribution of Section 136 detainees more closely reflects the general population than the overall custody population, with a relatively higher proportion of females compared to standard custody figures. The Panel noted that this may reflect broader patterns in mental health crises within the community, rather than custody-specific processes, and may also indicate limited alternative places of safety outside of custody environments.

Given the relatively small sample size and lack of comparative trend data, the Panel advised that no firm conclusions could be drawn regarding disproportionality within this cohort.

Mental Health – Force Response

No specific additional comments were provided by Force in relation to the Section 136 data. However, it is recognised that mental health-related detentions involve factors beyond custody control, including wider system capacity and availability of appropriate places of safety.



9. All topics - HMIC Recommendations and Force Progress.

The panel members were provided with the HMICFRS recommendations from the last inspection in 2018 prior to the meeting and an update as to where the Constabulary are at now.

PS explained that there was no update to give on this as there has not been a new inspection since the panel looked at them last year. The panel was asked whether they had any comments regarding the documents provided, but no issues were raised.

10. Any other business

PS asked if the panel had any other business.

No one had any other business.

Meeting concluded.

Next Meeting: Tuesday 28th July 2026 1:00pm-3:00pm