



Derbyshire  
Police and Crime  
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## Custody Detention Scrutiny Panel



Derbyshire  
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Protecting Communities  
Fighting Crime



# CUSTODY DETENTION SCRUTINY PANEL

## 2024/25 Annual Report

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Welcome to Derbyshire’s Custody Detention Scrutiny Panel (CDSP) Annual Report.

This report provides an overview of the activities and impact of the CDSP in Derbyshire for the year 2024–2025. It highlights the work of our dedicated panel members, the findings from panel meetings, and the improvements made to uphold public confidence in policing.

## What is the Custody Detention Scrutiny Panel?

Over recent years, several independent reviews, including the Lammy Review, Angiolini Review, and the Commission on Race and Ethnic Disparities (CRED), have highlighted disparities and inequalities within the Criminal Justice System. These issues have contributed to a trust deficit between communities and the police. One of CRED's key aims is to "build trust between different communities and institutions that serve them." Despite efforts such as mandatory training on discrimination and race issues, confidence gaps remain.

The Custody Detention Scrutiny Panel, hereafter referred to as 'CDSP' was established to provide independent oversight of custody practices. Its core objectives are to:

- I. Assess and report on detention and custody processes;
- II. Review and advise on matters of disproportionality; and
- III. Produce transparent findings for public consideration at the end of each annual cycle.

While scrutiny panels such as Stop & Search Panels exist nationally, there has been no consistent approach to addressing disproportionality within custody settings. The CDSP aims to fill this gap, promoting transparency and accountability and helping to build trust and confidence among all communities.

## The Purpose of the CDSPs

The CDSP is made up of local people from across Derbyshire who represent community perspectives in discussions with officers and staff working in custody environments. Members are given access to relevant police material to independently review issues of disproportionality and detainee treatment within the framework of legislation, guidance, policy, and procedure.

Ensuring custody procedures are proportionate, lawful, and necessary is fundamental to public trust in policing. The CDSP provides a safe and transparent forum for objective assessment of police conduct in custody, reinforcing accountability and confidence in the system.

## Aim and Role of the Panel

The main aim and purpose of the CDSPs is to:

- I. Examine disproportionality in the application of police powers in a custody setting, notably on grounds of race/protected characteristics.
- II. Ensure partnership review and scrutiny of police detention procedures from start to finish, including appropriate use of custody data and analyse data trends relating to custody matters and ongoing annual/quarterly data analysis.
- III. Consider wider issues where the Panel feels it could add value e.g. issues of safety and dignity.
- IV. Build trust and confidence of the local communities through transparency, accountability, engagement, and understanding of Criminal Justice and custody processes. Panel members are to act as a critical friend to Derbyshire Constabulary and provide advice and guidance to improve its performance around Custody Processes.
- V. Make observations and raise issues and recommendations to the OPCC and Derbyshire Constabulary representatives in attendance. This feedback can then be presented to officers and supervision individually at an appropriate time. Outcomes will also be fed back through the OPCC and CDSPs.
- VI. Report back to the wider policing area in the form of published minutes and a public facing annual report covering the findings of the CDSP in the preceding year. This annual report will also serve as a way of measuring the panels productivity and value to the community. It will enable all parties to ensure the panel is focusing on the correct aspects in relation to custody.

## Overview of the Derbyshire CDSP

The Derbyshire CDSP is coordinated by the OPCC. During the 2024/25 reporting year, the panel was supported by nine volunteers representing a diverse range of ages and backgrounds. All panel members also served as Independent Custody Visitors (ICVs) and participate in Custody Record Reviews (CRRs), bringing valuable experience and insight to the scrutiny process.

The ICV scheme is a statutory program that enables trained volunteers from the local community to make unannounced visits to police custody suites. Their role is to check on the welfare of detainees, ensure their rights are upheld, and confirm that custody conditions are appropriate. This independent oversight promotes transparency and helps maintain public confidence in the treatment of individuals in detention.

The CRR scheme complements the ICV program by allowing volunteers to review up to five redacted custody records remotely each week. These reviews focus on identifying issues affecting vulnerable individuals, such as juveniles, those with mental health concerns, women, and cases involving strip searches or immigration matters. Findings are reported to the OPCC and custody leads to address concerns and improve standards.

Having panel members who are actively involved in these schemes means they already possess a strong understanding of custody environments. This dual involvement enables them to monitor findings and areas of concern more closely, both during visits and at CDSP meetings.

To ensure thorough scrutiny, the panel is divided into two groups of four, with a designated spokesperson. Each group attends two meetings per year, meaning it takes two years for every group to review all topics. The spokesperson attends every meeting and is responsible for coordinating a pre-meeting discussion and preparing a report summarising the group's findings.

## The Topics Covered by the Panel

- I. Strip Searches
- II. Bail Refusals (Adult/Children)
- III. Custody Related Criminal Justice Decision Points
- IV. Dignity and Respect
- V. Length of Detention
- VI. Use of Force (UoF) (it is acknowledged that forces may have existing processes to scrutinise use of force generally)
- VII. Deaths in Custody
- VIII. Access to services (e.g. language service provisions, CANW (Appropriate Adult (AA) provider), HCP, Drugs Misuse etc).
- IX. Mental Health
- X. Use of Anti-rip Suits/Clothing
- XI. Custody Policies and Procedures
- XII. Other Topics at the Request of the Panel

The panel members may be able to request any other documentation, footage or appropriate material held by the Derbyshire Constabulary in relation to any concluded detention event that might contribute to the consideration of disproportionality.

## Key Findings for Each Topic

### Strip Search

#### What is a strip search?

A strip search is a police search involving the removal of more than outer clothing, carried out where an officer has reasonable grounds to believe that a detainee may be concealing items which could pose a risk to themselves or others, or which may be evidence relating to an offence. Strip searches are subject to strict legal safeguards and must be authorised, necessary, proportionate, and conducted in a manner that preserves dignity, including being undertaken by officers of the same sex and, where possible, in stages rather than requiring full removal of clothing at once. For juveniles and vulnerable adults, additional safeguards apply, including the involvement of an Appropriate Adult (AA).

#### Panel Findings – Good practice

The Panel reviewed a number of custody records relating to strip searches during the year. Overall, the Panel found that the Constabulary's Standard Operating Procedure (SOP) for Strip Searches was generally followed in the cases reviewed.

In all cases examined, authorisation for the strip search was clearly recorded, and the officers who conducted the search were identifiable on the custody record. The Panel assessed the rationale for searches as generally reasonable and proportionate, commonly relating to concerns around self-harm, concealed drugs, or other prohibited items. Importantly, the Panel noted that internal Constabulary scrutiny aligned with the Panel's assessments, providing additional assurance that strip searches were being appropriately reviewed.

Safeguards designed to protect dignity were reiterated throughout discussions. The Panel was assured that detainees are not required to be fully naked, with searches being conducted in sections (top half then bottom half), and that multiple officers are present to maintain safety and accountability. In cases involving juveniles, the presence and role of AAs was discussed in detail and clarified, including that AAs may be present inside the room or outside within hearing distance, depending on the detainee's wishes.

The Panel also noted evidence of post-incident oversight, with every strip search being reviewed by an Inspector. This internal review process was viewed positively and was seen to have contributed to improvements in data capture, including monitoring for disproportionality.

## Statistics and recording

The Panel recognised that an apparent increase in the number of recorded strip searches during the year was attributable to a change in recording practices, rather than an increase in actual use. The Panel welcomed this clarification and acknowledged that improved recording supports better transparency and scrutiny.

## Concerns Raised

While operational practice was generally robust, the Panel identified recurring shortcomings in recording quality and consistency, which limited its ability to fully assure itself that all safeguards were being applied in every case.

In particular:

- I. Rationale descriptions were sometimes limited, with insufficient case-specific detail. The Panel felt that clearer recording of the context of the arrest could better support assessments of proportionality.
- II. The location of the strip search was not always recorded, requiring the Panel to make assumptions about where the search took place.
- III. CCTV monitoring status (for example, confirmation that screens were turned off in the back office) was not consistently documented, despite being an important safeguard.
- IV. Outcome recording was inconsistent, with terms such as “nothing found” used instead of standardised descriptors such as “positive” or “negative”.
- V. The gender of searching officers and AAs was not always explicitly recorded, even where individuals could theoretically be identified by name or collar number.
- VI. In one case, the Panel identified a potential concern regarding the presence of the authorising officer during the search and the number of officers present. This was highlighted as inappropriate practice and referred back to the Constabulary for review.

The Panel also noted that the custody record format itself does not easily allow for certain important safeguards to be documented, including:

- I. Whether the detainee was informed of the need for the strip search
- II. Whether officers explained the requirement to remove clothing
- III. Confirmation that the search was conducted in stages

Additionally, panel members commented that access to risk assessments and medical records (where legally permissible) would enhance scrutiny and understanding of decision-making.

Finally, the Panel felt it would be informative to scrutinise the use of restraint during strip searches in future reviews, given the heightened sensitivity and vulnerability associated with such procedures.

## **Summary**

In summary, the Panel found that strip searches were generally lawful, justified, and appropriately authorised, with strong evidence of internal oversight and awareness of safeguarding requirements. However, record-keeping weaknesses remain a consistent risk. Improving the clarity, completeness, and consistency of documentation would significantly strengthen accountability, transparency, and public confidence in this area of custody practice.

## **Bail Refusals**

### **What is a refusal of bail?**

When a detainee is charged with an offence, a decision must be made about whether they are released on bail or kept in custody to appear before a court. A refusal of bail occurs where the custody officer determines that releasing the individual would pose an unacceptable risk, for example due to the likelihood of further offending, failure to attend court, risk of interference with witnesses, or where the individual is already subject to a warrant or has breached existing bail conditions. Bail decisions must be lawful, proportionate, and justified, and are subject to ongoing review while the detainee remains in custody.

### **Panel Findings – Good practice**

The Panel reviewed a number of custody records relating to refusals of bail. Discussions during scrutiny confirmed that the custody Sergeant is the decision-maker in relation to bail, and this line of accountability was reaffirmed during the meeting.

Where the custody records were correctly interpreted, the Panel found that decisions to refuse bail were generally rationalised, justified, and clearly reasoned, particularly in cases where detainees were:

- Subject to a warrant
- In breach of bail
- Unlikely to attend court if released

The concept of a “warrant not backed for bail” was clearly explained by the Constabulary, which strengthened the Panel’s understanding of why refusal of bail can be largely unavoidable in certain circumstances. This clarification assisted the Panel in placing individual decisions into an appropriate legal context.

### **Panel discussion and learning**

The Panel queried the value of scrutinising some refusal-of-bail cases, particularly where refusal was effectively inevitable, such as where detainees were:

- Arrested on a warrant
- Already in breach of bail conditions

Panel members felt that future scrutiny may be more informative if it included a broader mix of cases, including those where bail decisions required a greater level of discretion.

The Panel also expressed that it would be helpful for custody records to clearly identify the rank of the officer refusing bail, to further strengthen transparency and accountability within the decision-making process.

## **Concerns Raised**

Record clarity and transparency:

The Panel consistently found that custody records relating to bail refusals were difficult to follow, largely due to:

- Conflicting or unclear terminology (e.g. “bail denied”, “conditional bail”, “bail refused”)
- Automatically generated disposal entries appearing alongside custody decision logs
- Justifications for refusal sometimes appearing later in the record, rather than clearly at the point of decision

These issues created confusion and required additional explanation during meetings to understand what decision had ultimately been made and why.

While verbal clarification resolved many of these queries, the Panel noted that record-keeping must stand alone, particularly for public accountability and independent scrutiny.

## **Representativeness and disproportionality**

In the cases reviewed during the year:

- There were no refusals of bail involving juveniles
- No cases involving women or individuals from ethnic minority backgrounds

This lack of diversity limited the Panel’s ability to assess potential disproportionality in bail decision-making. The Panel requested that, where possible, future samples include a wider demographic spread to strengthen assurance and fairness oversight.

## Summary

Overall, the Panel found that decisions to refuse bail were generally lawful and justified, with appropriate Sergeant oversight and sound legal reasoning when clearly recorded. However, the Panel identified significant weaknesses in the clarity and accessibility of custody records, which limited effective scrutiny. Improving the consistency and presentation of bail decision records, and broadening the range of cases reviewed, would enhance transparency, disproportionality monitoring, and public confidence in this area of custody practice.

## **Dignity and Respect**

The Panel expects that all individuals held in police custody are treated with dignity and respect at all times, in line with the Police and Criminal Evidence Act (PACE) and the associated Codes of Practice. This includes ensuring that detainees are:

- I. Clearly informed of their rights and entitlements
- II. Provided with food and drink at regular intervals
- III. Offered suitable bedding and a blanket, where required
- IV. Given access to hygiene items, including toiletries and sanitary products
- V. Offered reading and distraction materials
- VI. Appropriately accommodated within the custody environment
- VII. Subject to regular welfare checks and reviews
- VIII. Provided with relevant information leaflets, including at release
- IX. Released with pre-release checks and support completed

The Panel also expects that these safeguards are accurately and consistently recorded within custody records to demonstrate compliance and support transparency and accountability.

## **Panel Findings – Good Practice**

The Panel recorded no major concerns in relation to dignity and respect during the period under review. As a whole, the custody records scrutinised demonstrated good standards of detainee care, often in challenging or complex circumstances, with general compliance with the Codes of Practice.

The Panel noted positively that:

- I. Food and drink were offered regularly, in line with expectations
- II. Detainees were informed of the availability of reading and distraction items, which was particularly welcomed
- III. Female detainees had access to Female Single Points of Contact (SPOCs)
- IV. Engagement with health and support services was evident where required
- V. Where detention extensions occurred, they were appropriately authorised and justified

During one quarter in particular, scrutiny highlighted consistently high levels of care, including timely access to healthcare, hygiene items, and welfare-focused engagement with detainees throughout their detention.

## Concerns Raised

While standards of care were generally high, the Panel identified a number of recurring documentation issues which limit effective scrutiny:

- Incomplete custody records, including:
  - The first few questions of the medical questionnaire not always being completed
  - Pre-release checklists occasionally left blank or partially completed
- Information recorded in HARDFACTS\* sometimes did not fully align with the detail contained elsewhere in the custody record
- The Panel felt it was likely that entries confirming the provision of information leaflets were system-generated, making it difficult to confirm whether information was actively explained to detainees

The Panel also observed that:

- Some detainees were not screened by the Criminal Justice Liaison and Diversion Team (CJLDT), or where screening took place, outcomes were not clearly recorded
- In one case, a detainee had two consecutive sleeping reviews on two occasions, which may have been related to the individual being remanded. Clearer explanation within the custody record would improve transparency and assurance.

In addition, while removal of personal clothing was generally well recorded and rationalised, panel members raised concerns during the year regarding dignity and proportionality in cases involving vulnerable detainees. These concerns were highlighted to the Constabulary, who committed to reviewing practice in this area.

*\*The HARDFACTS mnemonic should be used to record that due consideration has been given to the following:*

**H** – Health – *What health issues does the detainee have which may impact on their release or increase their vulnerability?*

*A – Alcohol and drug misuse – What issues does the detainee have with alcohol/drugs which may impact on their release?*

*R – Risk – What risk does the detainee pose to themselves on release from custody? Who else is likely to be at risk from the detainee upon their release from custody?*

*D – Domestic circumstances – Is this a factor on release? Are there any foreseeable problems at home upon the detainee being released?*

*F – Finances – What cash/bank cards does the detainee have with them to assist with travel?*

*A – Allegation – Could the nature of the offence being investigated have an impact on the detainee once they are released?*

*C – Clothing - Does the detainee have appropriate clothing to be released in?*

*T – Travel – What is the weather? What is the time of day? How will the detainee get home?*

*S – Support – What support does the detainee have from friends/family/other agencies? Should the detainee be referred or self-refer and to what agency?*

## **Statistics and data limitations**

Due to the nature of the topics reviewed by the Panel, specifically matters relating to dignity and respect, the Constabulary is not able to generate or provide quantitative data for these areas. As a result, the Panel was limited in its ability to draw meaningful conclusions or identify trends. This also presents a challenge for disproportionality analysis and evidence-based assurance.

## **Summary**

Overall, the Panel found that detainees were treated with dignity and respect, with custody staff consistently demonstrating good care and welfare-focused practice. Improvements in the completeness and consistency of record-keeping, particularly around medical screening, pre-release documentation, and CJLDT engagement, would further strengthen accountability and public confidence in custody provision.

## **Length of Detention**

Police custody operates within strict legal time limits set out in PACE. Detainees may only be held for defined periods, which must be:

- I. Lawfully authorised at specified intervals
- II. Regularly reviewed by officers of the appropriate rank
- III. Extended only where necessary and proportionate, with clear justification
- IV. Supported by appropriate welfare provision throughout detention

A core function of the Panel is to check whether these requirements are being complied with in practice and clearly evidenced within custody records.

## **Panel Findings – Good Practice**

The Panel found that length of detention was generally compliant with legal requirements well documented in the custody records reviewed.

Where detention was extended beyond standard time limits, in some cases up to 43 hours, these extensions were:

- I. Appropriately authorised, including by a Superintendent where required
- II. Supported by clear and detailed rationales
- III. Regularly reviewed in line with statutory requirements

Across the records scrutinised, the Panel concluded that custody staff demonstrated strong awareness of detention limits and review responsibilities.

The Panel also noted consistently high standards of care and welfare for detainees during periods of extended detention, including:

- I. Regular provision of food and drink
- II. Access to hygiene items and other welfare provisions
- III. Allocation of Female SPOCs where appropriate
- IV. Care planning and ongoing risk assessments throughout detention

There were also strong examples of multi-agency working, particularly in cases involving vulnerable detainees with mental health needs. This included engagement with:

- I. Mental health clinicians
- II. Support teams and liaison services
- III. Housing and social care arrangements

For juveniles, the Panel found that:

- I. Overnight detention was clearly justified and well recorded
- II. Social care involvement was evidenced
- III. AAs were engaged and safer detention practices applied

The Panel was further reassured by the Constabulary's open engagement with previous His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) Areas for Improvement (AFIs), and by transparent discussions around operational challenges, such as interpreter availability, including rare languages and British Sign Language provision.

## **Statistics and data limitations**

Panel consideration of detention statistics highlighted important limitations in available data:

- I. Initial figures suggested that detainees from ethnic minority backgrounds were held, on average, longer than White detainees (1,223 minutes compared to 725 minutes).
- II. However, the Panel noted that in approximately 50% of cases, ethnicity was either not stated or not recorded, significantly limiting the reliability of conclusions.
- III. Similarly, gender data was unavailable in around half of cases, further restricting meaningful comparative analysis.

As a result, while headline figures appeared to suggest potential disproportionality, the Panel was unable to draw firm conclusions based on the quality and completeness of the data. Importantly, within the individual custody records examined, the Panel identified no evidence of disproportionality in relation to detention length.

## Summary

Overall, the Panel found that detention time limits were being lawfully applied, reviewed, and documented, with good welfare provision and appropriate oversight throughout periods of detention. Strong safeguarding arrangements were evident, particularly for vulnerable individuals and juveniles. However, data quality limitations, especially relating to ethnicity and gender, continue to constrain broader disproportionality analysis and remain an area for ongoing development.

## Use of Force

### What is “use of force”?

Use of force refers to any physical restraint or intervention by police officers where it is necessary to prevent harm, maintain safety, or manage risk. In custody settings, this may include:

- I. Physical restraint techniques
- II. Handcuffing
- III. Use of leg restraints or spit guards
- IV. Taking a detainee to the ground

Any use of force must be lawful, necessary, proportionate, and the least intrusive option available, and must be recorded in line with the Derbyshire Constabulary Use of Force Policy.

### Panel Findings – Good Practice

The Panel examined five cases involving use of force in custody, using the Force’s Use of Force Policy as the benchmark for scrutiny.

The Panel found that:

- I. Custody records generally provided thorough accounts of incidents
- II. Clear justification for the use of force was recorded in each case
- III. The majority of custody records identified the officers involved and referenced the completion of Use of Force reports

In all but one case, officers involved were instructed to complete use of force reports. However, as these reports are not routinely attached to the custody record, the Panel could not independently verify whether all reports had been completed.

Scrutiny was significantly enhanced by the availability of CCTV and body-worn video (BWV) footage. Reviewing footage alongside custody records strengthened transparency and enabled the Panel to assess officer behaviour in real time.

The Panel observed clear evidence of de-escalation, including:

- I. Officers explaining actions before taking them
- II. Reassurance provided to detainees (for example, regarding breathing while wearing spit guards)

- III. Ongoing efforts to reduce the level of force as soon as the risk diminished

Panel members commended the professionalism and restraint shown by officers in highly volatile situations, particularly involving detainees who were intoxicated, experiencing mental ill health, or were juveniles or looked-after children. Where spit guards were used, these were well explained, closely monitored, and removed promptly when risk reduced, with safeguards evident to prevent positional asphyxia.

## **Complaints and procedural fairness**

The Panel reviewed information relating to complaints about use of force and was provided with a clear explanation of the complaints and Professional Standards process.

The Panel noted that:

- I. The majority of complaints related to allegations of man-handling, assault, or dragging
- II. Only one out of 21 cases where ethnicity was known involved a detainee from an ethnic minority background, which may become an area for trend monitoring
- III. Complaints relating to use of force are sometimes held pending the outcome of criminal proceedings to ensure procedural justice

While Panel members had limited information about complaint outcomes or investigative context, reassurance was provided that:

- I. Officers receive appropriate support during prolonged complaint processes
- II. Complaints are not recorded as misconduct findings unless substantiated
- III. Detainees are clearly informed of how to make a complaint

This explanation increased Panel confidence in the integrity of the complaints process.

## **Concerns Raised**

Despite generally strong practice, the Panel identified recording inconsistencies which limit effective scrutiny:

- I. Timestamp discrepancies between auto-generated entries and actual submission times created confusion

- II. In some cases, not all officers involved were clearly identifiable within the custody record, particularly where officers took over roles during incidents

Improving the consistency of recording and linkage between custody records and use of force reports would further strengthen accountability and assurance.

## Summary

Overall, the Panel found that use of force in custody was generally lawful, proportionate, and justified, with strong evidence of de-escalation and safeguarding practice. The main area for improvement remains recording clarity and completeness, particularly in ensuring that use of force documentation can be clearly followed and independently scrutinised.

## **Deaths in Custody**

Deaths in custody are a critical area of national and local scrutiny, requiring robust governance, clear accountability, and compliance with legal, policy, and inspection frameworks. The Panel's role is to review available data, policies, and force assurance to ensure appropriate safeguards and oversight are in place.

### **Panel Findings – Good Practice**

During the reporting year, the Panel noted that there were no deaths in custody within Derbyshire Constabulary.

The Panel reviewed the information provided relating to:

- I. Deaths in custody statistics
- II. Relevant force policies and procedures
- III. Applicable law and HMICFRS recommended AFIs

No concerns were raised in relation to any of these areas. Panel members were satisfied with the information presented and assured that appropriate governance arrangements are in place should a death in custody occur.

### **Summary**

The absence of deaths in custody during the reporting period is a positive outcome. The Panel will continue to maintain oversight of this area to ensure that governance, policy compliance, and preparedness remain robust.

## Mental Health

### **What services are available in custody?**

Detainees in police custody who present with mental health needs have access to a range of support services and safeguards. These include:

- I. Health Care Professionals (HCPs) within custody suites
- II. CJLDT
- III. Mental Health (MH) Clinicians
- IV. Access to health-based Places of Safety, such as the Radbourne Unit, including via Section 136 powers where appropriate
- V. AAs for detainees assessed as vulnerable
- VI. Referral and escalation pathways to A&E where a detainee is deemed unfit to be detained

Custody officers are expected to act in line with the Mental Health SOP, ensuring decisions are lawful, proportionate, and supported by clinical advice.

### **Panel Findings – Good practice**

The Panel scrutinised custody records relating specifically to mental health alongside the Mental Health SOP. While the cases reviewed were not necessarily representative of more typical scenarios, they demonstrated effective application of available pathways.

In one case, a bed was secured at the Radbourne Suite, and in another, the detainee was deemed unfit to detain and taken to A&E. The Panel acknowledged that these outcomes are not always achievable and recognised that, in many cases, custody staff must spend considerable time and effort attempting to secure appropriate facilities for detainees experiencing serious mental health crises.

Across the cases reviewed, the Panel noted:

- I. Effective multi-agency working, particularly with:
  - o CJLDT
  - o MH Clinicians
  - o The Radbourne Suite and Section 136 pathways
- II. Clear evidence that clinical advice informed decision-making
- III. Appropriate deployment of AAs where mental health need was identified

- IV. Decisions not to detain, or to release from custody, being supported by HCPs
- V. Custody officers acting within the MH SOP in the cases reviewed

The Panel also welcomed confirmation that improved availability of mental health beds over the past 18 months has reduced the amount of time detainees spend in custody awaiting assessment, which was viewed as a significant and positive development.

## Concerns Raised

While the Panel was generally satisfied with the handling of mental health-related cases, several learning points were identified.

In one case, the Panel noted that a Sergeant was unable to access the Mental Health SOP at the time it was needed. Although this did not appear to affect the overall outcome, the Panel highlighted that ready access to guidance is essential to support consistent and defensible decision-making.

Panel members also identified concerns around communication and understanding. One detainee, described as having schizophrenia, a brain injury, memory issues, and significant drug misuse, was recorded as being informed that they would be held incommunicado. The Panel did not see evidence in the custody record that it had been checked whether the detainee understood what this meant or why it was necessary, given his vulnerabilities. This was noted as an area where clearer documentation would enhance assurance around detainees' rights and comprehension.

## Summary

Overall, the Panel found that mental health needs identified in custody were appropriately responded to, with strong evidence of multi-agency working and clinically-informed decision-making. The Panel was reassured that custody officers acted within established procedures and that pathways to healthcare and places of safety were effectively utilised where available. Ensuring consistent access to guidance and clearer recording of how complex information is communicated to vulnerable detainees would further strengthen practice in this area.

## Use of Anti-rip Suites/Clothing

### Panel Findings

The Panel reviewed custody records relating to the use of safety suits and assessed these against the Constabulary's SOP.

In a case involving a male detainee, the Panel was satisfied that the use of a safety suit was clearly justified, proportionate, and consistent with the SOP. Although the recording did not follow the exact format recommended in the SOP, the Panel was able to understand the rationale, duration, and safeguards applied.

The second case, involving a female detainee, presented a more complex picture. The Panel recognised that this detainee posed a significant challenge to custody staff, repeatedly removing her clothing despite intervention. While it was clear that a safety suit had been issued in response to legitimate safety concerns, the Panel found it difficult to follow the timeline of its use, review, and removal within the custody record.

In both cases, the Panel noted positively that:

- I. Use of Force entries were properly recorded
- II. Critical Incident logs were well completed where relevant
- III. The overall rationale for issuing a safety suit was reasonable and proportionate

### Recording practice and the SOP

The Panel noted that the SOP specifies a detailed and structured entry within Niche under a designated "Safety Suit" section. This level of recording was not consistently reflected in the custody records reviewed.

Panel members questioned how this best-practice recording approach is expected to be embedded operationally, particularly when key information is instead dispersed across:

- I. Use of Force entries
- II. Welfare notes
- III. Care plans

While the necessary information often existed within the record, it was not always consolidated in a way that was easy to track, limiting effective scrutiny. However, we are aware that changing this is out of Forces remit.

## Concerns Raised

### Reviews and documentation

Although the Panel accepted that the use of safety suits was generally justified, concerns were raised about the consistency of review recording, including:

- I. Lack of clarity over the rank of the reviewing officer
- II. Absence of explicit reference to safety suit use during handover points
- III. Safety suit use not always being clearly reviewed at Inspector reviews, where expected

Additionally, some custody records lacked clarity around:

- When the safety suit was issued
- When it was reviewed
- When it was discontinued and normal clothing was restored

These gaps made timelines difficult to follow and required verbal explanation during meetings to fully understand what had occurred.

### Summary

The Panel found that the use of safety suits was generally proportionate and driven by legitimate safety concerns. Where applied, custody staff appeared to act in accordance with the intent of the SOP, and associated Use of Force and Critical Incident records were well documented. However, the Panel identified a clear need for more consistent and structured documentation, particularly in recording reviews, decision-makers, and key time points. Improving the clarity and consistency of safety suit recording would strengthen transparency, support effective scrutiny, and provide clearer assurance around the dignity and safeguarding of detainees.

## **Access to Services**

### **What Services are Available in Custody?**

Detainees in custody must be able to access a range of services to ensure their rights, welfare, and legal protections are upheld. These services include:

- I. AA services, for juveniles and vulnerable adults
- II. Legal advice, including access to duty solicitors and Defence Solicitor Contact Centres
- III. HCPs within custody suites
- IV. CJLDT
- V. Mental health and substance misuse services, including referral to specialist support
- VI. Language and interpreter services, including provision for non-English speakers and BSL users
- VII. Access to external service providers where required, such as A&E or health-based places of safety

The Panel's scrutiny focuses on the timeliness, appropriateness, and recording of access to these services, while recognising that some provider arrangements sit outside direct police control.

### **Panel Findings – Good practice**

The Panel reviewed custody records that included access to a range of services, particularly:

- I. AAs
- II. Solicitors
- III. HCPs
- IV. CJLDT

Overall, the Panel found that responses from service providers were generally satisfactory, and custody staff demonstrated appropriate escalation where detainee needs were identified.

Positive examples included:

- I. Effective use of Community Social Workers acting as AAs for juveniles
- II. Instances where AAs remained with juveniles throughout detention and at release
- III. Good coordination between custody staff and social care, supporting safeguarding arrangements
- IV. Timely healthcare engagement in several cases, with appropriate escalation to:
  - o A&E
  - o Liaison and Diversion teams
  - o CJLDT

The Panel also welcomed clear explanations provided in complex cases. For example, where a juvenile's family could not act as an AA due to prior involvement or exposure to evidential material, custody staff appropriately arranged alternative support, demonstrating awareness of safeguarding requirements.

## Concerns Raised

Scope and limits of scrutiny:

Panel members noted that it is sometimes difficult to determine where police responsibility for service provision begins and ends, particularly in relation to services delivered by external providers (for example, forensic services or facilities management). The Panel was not sighted on service level agreements with providers, which limits the depth of scrutiny that can be applied.

Recording and Clarity:

A recurring concern related to inconsistent recording of service access, including:

- I. Limited or absent records relating to interpreter services, despite their importance for safeguarding and informed consent
- II. Difficulty determining whether AAs or solicitors were present at release, particularly where records were heavily redacted

- III. Unclear use of the term “notified time” in custody records, with uncertainty as to whether this reflects the time a call was made, acknowledged, or responded to

In one case, although an AA was clearly required and appropriately arranged, the Panel did not see a record confirming who was present at the interview, which reduced assurance.

#### Delays and Safeguards:

Concerns were also raised about:

- I. Delays in notifying AAs, particularly for juveniles
- II. Interviews sometimes taking place before the arrival of an AA, or before AA presence was clearly recorded
- III. Presence of solicitors at interview not always being recorded within custody logs

Panel members highlighted the absence of a structured notification workflow for AAs, comparable to that used for solicitors. This was viewed as increasing the risk of delay and inconsistency, even where staff intentions were appropriate.

## Summary

The Panel found that access to key services in custody was generally appropriate and responsive, with particularly strong examples of safeguarding for juveniles and vulnerable detainees through the use of AAs and healthcare escalation. However, inconsistencies in recording and clarity, especially around notification times, interpreter provision, and confirmation of attendance at interviews and release, limited the Panel’s ability to fully assure itself that safeguards were consistently applied. Improving the transparency and consistency of recording, particularly in relation to AA processes, would strengthen accountability, safeguard detainees’ rights, and enhance public confidence in custody provision.

## Criminal Justice Decision Points & Performance Data

Whilst this was not a topic highlighted in the guidance for the panel to cover, the panel were asked to look at Criminal Justice Decision Points & Performance Data by the Head of Department for Criminal Justice & Custody.

This topic considers how custody-related criminal justice decisions are made and overseen, using performance data broken down by ethnicity, gender, and adult/juvenile status. It includes scrutiny of police-led charging decisions, the use of voluntary attendance (VA), out-of-court resolutions (OOCRs), and the overall quality and completeness of demographic data used to assess disproportionality.

### Panel Findings – Good practice

- I. Transparent reporting: Performance data were presented by ethnicity, gender, and age cohort, enabling focused scrutiny of disproportionality and trends.
- II. Candid on data limitations: The Constabulary openly acknowledged constraints in capturing self-defined ethnicity (SDE) (e.g., intoxication or non-compliance at booking in) and explained how officers seek to re-capture SDE later to improve completeness.
- III. Youth diversion: The Panel welcomed a reported 500% uplift in OOCRs for children (since Jan 2024) as a positive sign of proportionate, diversionary practice.
- IV. Voluntary Attendance (VA): The Force recognised under-utilisation of VA, particularly for younger people, and set out work to increase appropriate use.
- V. Charging decisions: In July, the Panel found no disparities within police-led charging decisions reviewed. The Force provided clear explanations of the boundary between police-charged and CPS-charged cases and the limits of police accountability where CPS authorisation is required.
- VI. OOCR Hub: The Panel welcomed the establishment of an Out of Court Resolutions Hub, noting improved consistency, proportionality, and a reduced risk of disproportionality in cautions and community resolutions.
- VII. Risk-based clothing decisions: A significant reduction in anti-rip clothing use was commended as evidence of stronger risk assessment and care planning.

## Areas for Improvement and Ongoing Monitoring

- I. Data completeness: High rates of “not stated/unknown” SDE (and some missing gender data) limit disproportionality analysis and year on year comparison. Continued work to improve demographic completeness is needed.
- II. Voluntary Attendance utilisation: The Panel supports plans to scale up VA where appropriate - particularly for children and vulnerable cohorts - and will monitor uptake, timeliness, and outcomes.
- III. Clarity on accountability points: Given the distinction between police led and CPS led decisions, future reporting would benefit from clearer signposting of who decides what, and when, so any disparities can be attributed and addressed at the correct decision point.
- IV. Evaluating the OOCR Hub: The Panel encourages ongoing evaluation of the Hub (e.g., time to decision, consistency across cohorts, outcomes by protected characteristics) to evidence sustained impact on fairness and proportionality.
- V. Data completeness: High rates of “not stated/unknown” SDE (and some missing gender data) limit disproportionality analysis and year on year comparison. Continued work to improve demographic completeness is needed

## Summary

Across January and July 2025, the Panel observed credible, transparent performance reporting, a marked increase in diversion for children, and strengthened decision-making governance (OOCR Hub; clear delineation of police vs CPS roles). The primary constraint remains data completeness, which tempers disproportionality analysis. The Panel will maintain oversight of VA utilisation, OOCR Hub outcomes, and demographic data quality to ensure improvements translate into equitable experiences and outcomes for detainees.

## General Observations (Non-Topic Related)

This section summarises overarching comments from the Panel that were not specific to any single topic but relate to the overall process of scrutiny, data presentation, and custody record access.

### Panel Findings – Good practice

- I. The Panel acknowledged the time and effort invested by the Constabulary in providing training, preparing custody records, and responding thoroughly to queries raised during meetings.
- II. Panel members valued the opportunity to discuss statistical data directly with Constabulary representatives, which enhanced understanding and allowed constructive feedback to be acted upon.
- III. The Panel noted steady improvements in the quality and clarity of data provided over the course of the year, including the introduction of percentage figures alongside absolute numbers and, where relevant, background totals for context.
- IV. Engagement was described as open and collaborative, with the Force demonstrating willingness to adapt processes in response to Panel suggestions.

### Concerns Raised

- I. Statistical presentation:
  - Early data sets were presented as absolute numbers only; the Panel requested percentages for greater clarity, which was subsequently implemented.
  - The Panel suggested that figures could be split by custody suite (Derby and Ripley) and that ethnic minority categories should be broken down into more specific ethnic groups to support meaningful disproportionality analysis.
  - Despite improvements, the high proportion of cases where ethnicity was “unknown” or “not stated” continues to limit the usefulness of comparisons and trend analysis.
- II. Custody record format and redaction:

- The Panel found that redaction of custody records sometimes hampered scrutiny, particularly in confirming whether AAs or solicitors were present at key stages such as interviews or release.
  - The format and extraction method for custody records made it difficult to access meaningful demographic data, especially self-defined ethnicity.
  - While improvements were noted, further work is needed to ensure critical information is retained for scrutiny without compromising confidentiality.
- III. Independence of record selection:
- Panel members observed that custody records were selected by the Constabulary, meaning scrutiny was not fully independent.
  - To strengthen independence, the Panel suggested that future exercises allow panel members to select records themselves, ideally from a pre-prepared list of anonymised record numbers.
  - The Panel recognised that this would require careful planning to avoid creating undue workload for either the Constabulary or the Panel.
- IV. Timelines and logistics:
- The Panel acknowledged that meeting deadlines for review was challenging during the first cycle but accepted this as part of a learning process for a new scrutiny model.

## Summary

The Panel commended the Constabulary for its constructive engagement and responsiveness throughout the year, noting clear improvements in data presentation and openness to feedback. Key areas for development include enhancing demographic data completeness, reducing the impact of redaction on scrutiny, and exploring mechanisms for more independent custody record selection. Addressing these issues will strengthen transparency, improve disproportionality analysis, and support the credibility of the scrutiny process.

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For more information on the CDSP, please see the dedicated page on our website, here: [Custody Detention Scrutiny Panels | Office of the Derbyshire Police and Crime Commissioner](#)



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