

# Independent Review

**A review of death in or following  
custody occurring within  
South Wales Police custody centres  
1 April 2004-1 April 2006**

**PAUL DAVIES  
SENIOR INVESTIGATOR**

## **FOREWORD**

The use of police cells as 'places of safety' for vulnerable people with mental health issues, drug or alcohol dependencies should only occur as a last resort.

Unfortunately, the police often have to deal with some of the most vulnerable people in society and sometimes with tragic consequences.

Deaths in police custody or following contact with the police have a devastating impact on the families of the deceased and on the police officers and staff who have dealt with those individuals. A police cell is often not the most appropriate place for somebody with health issues to be placed, and should only be used as a last resort. Often busy officers do not realise that the person they are arresting has mental health issues and requires medical attention not detention. There are also occasions when health service personnel call the police because the individual is becoming violent.

In these situations good training, policies and custody practices for police forces are imperative to ensure that the vulnerable individual receives the best possible care and does not become another statistical victim.

Following a number of deaths in custody or serious illness of people detained in South Wales Police custody centres which seemingly had some common recurring issues I commissioned a review of all previous cases of death in custody/adverse incidents which had been referred to the IPCC by South Wales Police since the Commission started in April 2004.

The purpose of the review was to establish if there were any re-occurring themes which could be brought to the attention of South Wales Police and other agencies for action to be taken and perhaps assist in preventing similar incidents from occurring in the future. South Wales Police welcomed this initiative by the IPCC and have co-operated fully with this review.

**TOM DAVIES**

**Commissioner for Wales**

## **INTRODUCTION**

This report concerns a review of cases involving the death or serious illness of individuals who were being, or had recently been detained within South Wales Police custody centres between 1 April 2004 and 1 April 2006.

The definition of a death in or following custody includes the death of persons who have been arrested or otherwise detained by the police. It includes death which occurs while a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

This report was commissioned following the cases of two individuals, one who was discovered dead in a local park the morning after being released from Cardiff Central Police Station and the second discovered suffering a fit while being detained at Cardiff Central Police Station. The following is a brief outline of their cases:

On 7 March 2006, police officers from South Wales Police were called to Charles Street, Cardiff following a report from a member of the public expressing concern for a male person who appeared to be collapsed on a bench.

A 41-year-old homeless man was arrested by officers for being drunk and incapable. He was taken to Cardiff Central Police Station where he was placed in a cell at 4.18pm on 7 March 2006. Despite being an alcoholic and a known epileptic no police surgeon was requested to examine him as specified under Code C of the Police and Criminal Evidence Act 1984.

He was checked regularly by custody staff during that evening and into the next morning. At 6.26am on 8 March 2006 he was discovered suffering a fit in his cell. An ambulance was called and he was taken to the University Hospital Wales where he was placed on a life-support machine. Fortunately he recovered from his condition and was discharged from hospital on 9 March 2006.

The incident was referred to the Independent Police Complaints Commission on 8 March 2006 by South Wales Police and IPCC Commissioner for Wales Tom Davies determined that this case would be an independent investigation undertaken by IPCC investigators.

This particular incident was not the first of its kind and followed on from an earlier case whose death followed his detention at Cardiff Police Station and was referred by South Wales Police to the Independent Police Complaints Commission on 23 January 2006. This was another homeless man who had been arrested for being drunk and incapable in Cardiff and was taken to Cardiff Central Police Station, detained and subsequently cautioned and released. He was found dead in a park in Cardiff the next day.

Initial investigation raised questions over procedural issues relating to his detention and IPCC Commissioner for Wales Tom Davies decided that this case would be a managed investigation with the IPCC maintaining direction and control of it.

These two incidents alone raised serious concerns over the welfare and treatment of detained persons, especially those from vulnerable groups, who were being arrested and detained in South Wales Police custody centres, and followed on from a number of other deaths in custody or near miss cases. Furthermore, IPCC figures on deaths following police contact for 2004/05 show that South Wales Police had a high number of deaths in police custody compared to the vast majority of other forces during this time. There were four deaths in custody in South Wales Police and none in the other forces in Wales. More broadly, South Wales Police had one less death in custody than the Metropolitan Police Service during this period, despite the MPS having a much greater number of people passing through its custody suites.

It is however acknowledged that South Wales Police experienced the highest number of detainees during this period than any of the four Welsh police forces. During 2005/2006 South Wales Police did not experience any deaths in custody -  
Appendix A.

The Commissioner, as part of his Guardianship role, and following consultation with South Wales Police, decided that the IPCC should undertake a review of all previous cases of death in custody/adverse incidents which had been referred to them by South Wales Police since the IPCC started operations on 1 April 2004.

The purpose of the review was to establish if there were any themes in these incidents which could be brought to the attention of South Wales Police and other agencies for remedial action to be taken and perhaps assist in preventing similar incidents from occurring in the future. One theme which features in the majority of the cases highlighted in this report is that of CCTV provision in SWP custody centres. A significant factor in many of the cases referred to the IPCC was the poor quality of the CCTV provision in custody centres, including a lack of audio in the recordings and inaccurate times.

South Wales Police welcomed this initiative and have fully co-operated with the IPCC review.

In publishing this review the names of individuals, whether living or deceased, have been removed.

## TERMS OF REFERENCE

The Terms of Reference for the Review were agreed as follows:

As a result of a number of recent referrals from South Wales Police, a review will be undertaken in relation to the care and treatment of persons detained in South Wales Police custody centres due to a proportionally high number of deaths in custody and near miss cases compared to other forces in the region.

A review will be conducted of all death in custody or near miss cases referred to the IPCC since 1 April 2004, to establish if there are any common factors or failings in these incidents which can be brought to the attention of South Wales Police for their consideration of further action.

---

Definitions of death in custody or following police contact are detailed in Appendix B.

All IPCC activities, including investigations, casework and appeals contribute to its wider Guardianship role. This role has four elements:

- Setting, monitoring, inspecting and reviewing standards for the operation of the police complaints system
- Promoting confidence in the complaints system as a whole, amongst the public and the police
- Ensuring the accessibility of the complaint's system
- Promoting policing excellence by drawing out and feeding back learning.

The element of drawing out and feeding back on lessons learnt is an important part of investigations. A past criticism has been that deaths/near misses following police contact might have been avoided if lessons from previous investigations had been put into practice on a national basis.

Completed IPCC investigations produce recommendations, and which in turn often contain advice to the force on matters requiring improvement. Some investigations

produce recommendations for changes to national policy (national recommendations), while others recommend changes specific to the force (local recommendations). These local recommendations may nonetheless provide learning opportunities for other forces managing similar situations. Investigations may also identify good practice. Some of these recommendations will need to be circulated to the force and disseminated to the police service at an early stage. Others can wait until the end of the investigation. An interagency forum, currently called the Learning the Lessons Committee, has been set up to effect dissemination of learning. Members consist of representatives of the IPCC, Home Office, Association of Chief Police Officers, National Policing Improvement Agency, Association of Police Authorities and Her Majesty's Inspectorate of Constabulary.

The IPCC has a statutory duty under the Police Reform Act to increase public confidence in the police complaints system in England and Wales and, in so doing, to contribute to increasing confidence in the police as a whole. This oversight of lessons learned from investigations, identification of good practice, and use of IPCC powers of oversight and influence go some way to achieving this aim.

It was with this backdrop that this review has been commissioned and will examine relevant cases referred to the IPCC by South Wales Police between 1 April 2004 and 1 April 2006.

## **METHODOLOGY**

Research of the IPCC Case Tracking Management System (CTMS) initially identified a total of 18 cases of death in custody/death following police contact or relevant adverse incidents, which had been referred to the IPCC by South Wales Police in the period since the Commission's inception in April 2004 to 1 April 2006. These cases included all deaths following police contact, even though some of the individuals may not have been brought into police custody.

Following detailed examination of these cases, and in consultation with the IPCC commissioner, a total of eight cases were considered as falling within the Terms of Reference of this review.

Significantly, three of these cases occurred between January and March 2006 involving individuals who had been detained at Cardiff custody centres.

A small team of IPCC investigators have considered each of these eight cases and produced a detailed check-list of what is considered relevant information, which could be used to cross-check detail across all of the cases, in order to identify any common issues - Appendix C. This information included such detail as age, gender, health status, through to activity within the custody centre in terms of reviews, examination by the Force Medical Officer, Police National Computer warning markers etc.

In addition, a review was undertaken of the investigation report in each case with particular emphasis on the circumstances of the contact with the individual and the police. The circumstances of the actual incident itself, together with conclusions and any recommendations arising, both in respect of criminal/misconduct matters and organisational learning were also examined.

## **CASES REVIEWED**

The eight cases subject to review are as follows:-

### **1. Case Study 1**

#### **IPCC supervised investigation undertaken by West Midlands Police**

##### **Brief summary of the incident**

Person A at the time of his arrest was a 47 year-old man with a history of mental health problems, including schizophrenia. He also suffered from the physical disability of Ankylosing Spondylitis, which causes curvature and brittleness of the spine.

Person A telephoned Barry Hospital at 6.10pm on Saturday, 17 April 2004. He informed staff that he had tried to cut his hand off with a kitchen knife but it wouldn't cut through so he was going to try a saw. He made other odd statements such as 'the dogs are talking backwards.'

The on-call doctor (Dr A) attended Person A at his home address at around 7.35pm accompanied by two police officers. They and two neighbours managed to gain entry to the address after about 30 minutes of negotiation with Person A, who had refused them entry.

The doctor noted a superficial injury to Person A's left wrist. The police officers ensured he was not carrying any weapon of offence after which Dr A decided they could leave.

Shortly afterwards Person A became aggressive towards one of his neighbours who had assisted the police. He then became verbally abusive to the doctor who also left for her own safety. Person A remained in the flat with one of his neighbours.

The doctor decided that Person A needed psychiatric help and was unlikely to go voluntarily. She alerted an approved doctor and social worker in anticipation of sectioning Person A under the Mental Health Act.

There then followed a period of about 45 minutes where Person A refused entry to police, neighbours, the doctor and his brother. The police officers became fearful of the welfare of both Person A and his neighbour and prepared to forcibly enter the premises. But before they could implement the plan, the neighbour managed to open the front door and allow them entry.

The officers arrested Person A for Breach of the Peace and attempted to restrain him, first by laying him on his bed and then by removing him to the floor. Person A resisted violently and it was some 20 minutes before the officers were in a position to remove him from the premises and take him in a police van to Barry Police Station.

At around 9.40pm Person A arrived at Barry Police Station and again began to struggle. He was carried straight to the 'drunk' cell, which contained a low bed a few inches off the ground.

This cell is covered by CCTV. Several police officers and civilian detention officers are seen on the CCTV coverage to accompany Person A to the cell. An attempt is made to search him and remove his trousers (which contained a drawstring) during which he struggled violently and numerous officers and detention staff attempted to restrain him.

Person A calmed down after a short period and was subsequently seen by a Force Medical Examiner (FME). After 40 minutes talking with Person A he decided that hospitalisation at that time was not warranted.

Dr C, a psychiatric registrar called by Dr A as part of the Sectioning process, then saw Person A along with a social worker. Person A was on his right-side, facing the cell wall. He remained generally motionless and mainly nodded responses to questions. Both doctors C and A, as well as the social worker, agreed that Person A should be Sectioned but found that there was no bed available throughout the whole of Wales at that time, despite extensive enquiries by both the health professionals and police. On leaving the police station Dr C discovered that a bed was available in London but decided transfer at that time was not practicable and Person A should

remain in custody. It was agreed that he should remain at the police station as a place of safety, until suitable arrangements could be made.

Person A remained in the cell overnight and is observed by CCTV to remain throughout the night lying on his right-side with his head facing the cell wall. He is visited frequently and apparently gives verbal reassurances to custody staff that he is okay, but he does not move position.

At 9.44am on Sunday 18 April 2004, Person A is seen on the CCTV to roll onto his back and then onto the floor beside the bed, He then rolls onto his left-side into the centre of the cell. At 10.09am a police officer is seen to enter the cell and, with the help of other custody staff, drags Person A back to the bed and again into a position on his right-side facing the wall.

The psychiatric registrar continued arrangements for accommodating Person A at a mental health hospital during Sunday morning. Before the process was completed, around 12.20pm, Person A made a complaint to custody staff about being unable to move his legs and the force medical examiner was summoned. The FME again examined him at 1.20pm and decided to await the arrival of the psychiatric registrar before determining whether ordinary hospitalisation was now necessary.

The psychiatric registrar attended at 3.30pm for the purpose of following up the procedures for Sectioning Person A under the Mental Health Act. However, after conducting her own examination, she decided his medical conditions should take priority and she arranged for an emergency medical admission to Llandough Hospital. She feared that Person A had suffered a stroke. Both doctors left before an ambulance arrived, which transported Person A to the hospital at 5.45pm. Person A therefore remained in police custody throughout this time.

On arrival at Llandough Hospital, Person A is reported as being calm and able to hold a conversation. X-rays were taken of his spine which showed that he suffered from spondylitis but no fractures were detected. Medical staff decided an urgent MRI scan was warranted and he was transferred to the University Hospital of Wales for this procedure. He arrived there around 0.05am on Monday 19 April. An MRI scan

was conducted immediately which showed that Person A had a fracture of the cervical spine causing severe stenosis of the spinal cord. A hard collar was applied to immobilise his neck and he was taken to the high dependency unit, arriving at around 2.20am.

At 2.40am Person A suffered a cardio-respiratory arrest. Resuscitation efforts by medical staff were unsuccessful and he was declared dead at 2.55am.

A subsequent post-mortem examination revealed that Person A had died following respiratory arrest owing to a fatal neurological lesion caused by a fracture to the cervical spine.

The subsequent police investigation highlighted that there were issues over the quality of the CCTV system installed at Barry Police Station with the quality of the camera in the cell that Person A was placed being particularly poor. It is believed this was caused a previous prisoner tampering with the camera lens.

The investigation also highlighted inconsistencies with the custody staff visits said to have been undertaken. CCTV highlighted visits that were not recorded on the custody record and visits that were recorded on the custody record but were not corroborated by the CCTV.

Recommendations were made in respect of misconduct for a number of officers. Two sergeants to receive formal written warnings over minimum standards of care under the Police and Criminal Evidence Act, four officers to receive advice for failing to pass on relevant details over the arrest and an inspector and three detention officers to receive advice for making entries on the custody record under identification details of other officers.

## **2. Case Study 2**

### **IPCC supervised investigation**

#### **Brief summary of the incident**

Person B was a known alcoholic who had a chronic drink problem. He was known to have been living on the streets for up to one year before his death and was of no fixed abode. His alcohol intake prior to his death was known to be at least two litres of strong cider per day, which at times had risen to up to six litres per day.

On the morning of 1 June 2004, he and a companion, Ms J, were seen in the area of McDonalds, Swansea city centre. They were approached by an outreach worker from a church group who regularly assisted street dwellers.

Person B stated to the outreach worker that he needed to go back onto a detoxification programme and asked if she could assist.

After collecting his benefits from the Kingsway post office, Person B and Ms J remained on the steps to the building and continued to drink. It was then that they were seen by a Warrants Officer, who recognised Person B and noted that there was an outstanding warrant for his arrest. A police officer attended in support and he was arrested.

Person B was very drunk and unable to be roused when detained and on arrival at the custody suite at Swansea central police station he was taken by a custody sergeant and civilian detention officer to male cell No. 2. He was not given his rights at this point due to his intoxication. The risk assessment carried out did not identify any cause for concern. The custody officer did ensure that he be checked every 30 minutes in accordance with the provisions of the Police and Criminal Evidence Act.

At 5.17pm the same day he was sober enough to be allowed to exercise in the yard area and a short time later provided with a hot meal.

His detention was reviewed at 5.35pm by an inspector who has stated that he had no recollection that Person B was unwell, or that his condition posed any significant risk. At 6.23pm he was given his legal rights.

At 11.45pm he was charged with offences of drunkenness and held for court the following morning due to his previous history. He was returned to his cell and checked regularly.

A number of checks were made where the visiting custody detention officer (CDO) was able to state that Person B was alive and seemingly well.

At 6.15am on 2 June 2004 a CDO checked Person B and was concerned for his welfare as he was not visibly moving or breathing. No pulse could be located and no breathing detected and an attempt was made to rouse him but this was unsuccessful and an ambulance was called.

A custody sergeant began Cardiac Pulmonary Resuscitation, while a CDO located the defibrillator unit housed within the custody suite. The ambulance crew attended and took over in the attempt to resuscitate Person B. They were unsuccessful in their attempt and at 8.07am the force medical officer attended and pronounced life extinct.

The deceased was photographed in situ at 8.07am and later a video recording was made of the scene. The Home Office Pathologist attended and conducted a preliminary examination in situ.

A post-mortem was conducted on 4 June 2004 and the result was inconclusive as to the cause of death. Forensic and tissue samples were retained for further examination and testing.

### **Police investigation**

South Wales Police Professional Standards Department began their investigation into the death of Person B. The custody record and all CCTV evidence was seized, as were some items of clothing worn by the staff that day.

Accounts were recorded from all staff and prisoners in custody at the time. The file relating to the deceased's criminal charge was also retained. Enquiries revealed that the lifestyle of Person B was that of a chronic alcoholic and occasional drug user.

The buzzer system in Cell No. 2 was found to be inoperative, though fingerprint evidence from the site showed that Person B had not attempted to use it.

Following further examination the cause of death was stated as '...history of epilepsy and is most likely to have been a sudden death in epilepsy.'

There was no evidence to suggest that any staff had acted improperly at anytime during the detention of Person B. Indeed, two individuals were given commendations from the Chief Constable and two from district commanders.

### **Recommendations**

This related to the use and operation of the cell buzzer system and the custody record computer system. Both required minor changes. There was no criticism of the actions of any custody staff.

### **3. Case Study 3**

#### **IPCC supervised investigation**

##### **Brief summary of the incident**

At 4.02pm on Friday the 4 June 2004 Person C was pronounced dead at the casualty unit, Singleton hospital, Swansea, having been taken there by ambulance. He had been found collapsed in the rear of a police transport van, at Swansea central police station, following his earlier arrest for indecent exposure at Argyle Park, Gorseinon, Swansea.

The deceased was an individual with a known history of alcoholism. On the date in question Person C was considered to be drunk by his associates, the police officers involved in his arrest and an independent witness. The earliest observation of his “drunken” condition was at 8.10am on 4 June 2004. A number of witnesses stated that Person C had glazed eyes, slurred speech and smelled strongly of intoxicants, excrement and body odour. He commented to his friends that he had been unwell for three weeks but refused to see a doctor. A neighbour stated that in the two weeks prior to his death he had heard the deceased, through the adjoining flat walls, coughing violently and vomiting.

The circumstances of the arrest were that while sitting on a bench in Argyle Park with Friend 1, Person C undid his belt and pulled his trousers down to his ankles. Friend 1 noting that he smelled strongly of excrement moved to another bench leaving Person C in a state of undress. Person C then removed his top leaving himself totally naked in view of members of the public using the park. Another associate of Person C, Friend 2, joined Friend 1 and reported the indecent exposure to the police because of the number of women and children in the park.

At approximately 3pm two police officers attended the scene in separate vehicles. Approaching Person C, the officers noticed he was “bare-chested,” his trousers were secured with a thin piece of wire but open, he wore no underwear and there was a can of cider near his right foot.

They engaged Person C in conversation and he gave his name and address and the officers explained the nature of the complaint that had been made against him. After cautioning he made no reply and the officers formed the opinion he was drunk based on the symptoms described above. Person C rose from the bench unaided and walked, again unaided, to the park exit accompanied by the officers.

He did appear to lose his balance before reaching the park exit and the officers had to take an arm each to assist him. Once outside the park his legs appeared to “go from under him” and he dropped to his knees on the pavement. He was subsequently arrested. A third officer had arrived in a separate vehicle and he assisted the other officers in lifting Person C to his feet.

The officers then placed him in the recovery position in the secure cage in the rear of a police van and noted he was breathing normally. One officer risk assessed the situation and decided that he presented very little risk to her personal safety. She took the decision to convey Person C alone, enabling the other two officers to return to other duties. She then checked he was still breathing and started to drive to the police station.

While stationary at traffic lights en-route to the station, a journey which took approximately 20-25 minutes, the officer shouted “Are you alright ...?” Person C did not reply and so she looked into the back of the van and saw him lying on the floor in the recovery position he had been put in originally. Nothing she saw caused her concern.

On arrival at the police station the officer could get no response from Person C. She noticed he did not appear to be breathing and on checking could not locate a pulse. She immediately went to the custody suite to summon help and a custody sergeant came out to the van to examine Person C. He established that he was not breathing but did have a weak pulse and instructed the officer to call for an ambulance via her personal radio, while he fetched resuscitation equipment from the custody suite.

They re-entered the van, placed Person C on his back and commenced resuscitation. The sergeant administered chest compressions while the officer used

the ANBA Silicone Resuscitator to force air into his lungs. Paramedics arrived and took over the resuscitation, assisted by the police officers. An ambulance arrived a short while later and Person C was conveyed to the Casualty Unit at Singleton Hospital. Resuscitation was continued but life was formally pronounced extinct at 4.02pm by a doctor. Ambulance records indicate arrival at the police station at 3.36pm.

Later forensic examination of Person C's blood and urine found there to be no alcohol in his blood specimen and only a very low level in his urine showing that he would not have been intoxicated at the time of his death. The Home Office Pathologist concluded that he had died from a pre-existing condition, namely lobar pneumonia.

### **Recommendations**

- That the South Wales Police Policy, *Prisoners – Conveyance in Police Custody*, be revised to include that all prisoners who are under the influence of alcohol or drugs and incapable of controlled action are to be accompanied by an escorting officer in addition to the driver.
- That no other action be taken against any officer from South Wales Police and further recommend that the report, statements, exhibits and other documents be made available to HM Coroner in order that the inquest may be finalised.

## **4. Case Study 4**

### **IPCC supervised investigation**

#### **Brief summary of the incident**

At the time of this incident 19-year-old Person D had been employed by [Redacted] in Swansea for approximately one year. On Friday 20 August 2004 he assisted with the cashing up at the end of the day and was asked to place £1,807.03 in the safe, which he did and then left the shop. It was discovered the following day that £1,805 was missing.

On Monday 23 August 2004, Person D went to police in Swansea and admitted the theft. He was arrested, dealt with for the offence and released from custody that afternoon at 1.18pm and bailed to appear at Magistrates Court on 27 August 2004. At approximately 7.45pm Person D was struck by a train and killed.

The Investigating Officer conducted enquiries into the events leading up to the death of Person D. Statements have been taken from all of his friends who had spent time in his company over the course of the weekend. They stated that Person D was spending money freely and that although he initially told them he had won some money on the horses, he later admitted to the theft. They all agree that this was out of character. His work colleagues have also provided statements in which they agree that the theft was totally out of character.

During the course of the investigation it was discovered that Person D had recently started to take Ecstasy, which was confirmed by the pathologist as traces were found in his body. Enquiries have failed to reveal where or when he obtained the Ecstasy prior to his death, although his friends have confirmed that he had started to take the drug while on nights out in Swansea.

Extensive enquiries have been made to establish Person D's whereabouts between leaving custody and his death. The investigation discovered that he talked to some friends about the theft. They describe him as being down and close to tears. Person D told them that he would go to his grandmother's house and that he would see them later. This was around 5.45pm. He was seen again by another friend who had

seen him earlier after he was released from custody - this was about 6pm and he was walking on his own. Person D then sent her a text message which she did not answer straightaway. She attempted to call him at about 7pm but he did not answer the phone.

The train driver involved in the collision describes Person D as crouching at the side of the track and then purposely standing up and deliberately diving in front of the train. There was nothing he could do to avoid a collision which resulted in immediate death.

The police officers who dealt with Person D over the theft allegation were interviewed but have stated that he did not give them any cause for concern during detention or on his release.

The solicitor who was present during interview also stated he had no cause for concern.

Enquiries did disclose that Person D had several debts but these were less than the amount taken by him. Although he may have been concerned, he did not attempt to repay the debts with the money he took. He chose instead to spend it over the course of the weekend on drinks, clothes and a wristwatch.

Friends, family and work colleagues all said that his behaviour had changed some months before his death. They describe him as becoming moody and withdrawn. When he was asked about his behaviour by friends and family he attributed it to growing up.

Despite extensive enquiries by the investigating officer the reason for his suicide is not known. There is nothing to suggest that his arrest or treatment in custody contributed to actions in taking his life.

## **Recommendations**

There were no recommendations arising from the investigations.

## **5. Case Study 5**

### **IPCC managed investigation**

#### **Brief summary of incident**

At 4.45pm on 10 October 2004, following a heavy drinking session, Person E was seen by a witness in Porthkerry Road, Barry, having what she thought was a fit.

At 5.15pm an ambulance was called and five minutes later the ambulance crew arrived and found Person E sitting on the pavement against a wall. The ambulance crew assessed him and his speech was recorded as clear and lucid, his pulse was 78bpm of good volume and regular, and his respiratory rate was 180/min. He had good peripheral circulation and although shivering his extremities were found to be warm.

Due to his apparent confused and itinerant condition, the police were called. A blanket was placed around Person E who then walked unaided to the ambulance. While in the ambulance he continued to decline hospital treatment.

The ambulance crew became concerned at the delay in the police attending the scene and called again - a police unit had attended the wrong location. Eventually the police arrived at 6.55pm and on leaving the ambulance Person E's jacket and shirt rode up revealing a knife concealed in the small of his back in the waistband of his trousers.

He was arrested at 6.55pm for possession of an offensive weapon, handcuffed behind his back and searched. Person E was compliant throughout and was then placed in the rear of a police vehicle. He walked to the police vehicle unaided and informed the arresting officers that he was an alcoholic and needed a drink. He requested a can of cider from his bag but this was refused by the officers.

On arrival at Barry police station he was brought before the custody sergeant and both he and an inspector spoke with Person E and he was told a doctor would attend to look at him, due to his shaking and overall demeanour. He again requested a drink of alcohol stating he would be ill if he didn't get a drink. This request was again

refused but he was given a drink of water some eight minutes after arriving in custody and after he had been placed in a cell.

Due to his antecedents and appearance the custody sergeant decided to take Person E straight to male cell 1 in order to search him.

A custody detention officer (CDO) and two arresting officers were also present at the search which is recorded on CCTV but without audio.

On completion of the search the handcuffs were removed. The officers then left Person E in male cell 1, sitting on a plastic-coated mattress at floor level.

A few moments later the custody sergeant and another officer returned to the cell with three plastic beakers of water and placed them on the floor at 7.13pm 21 seconds.

After 23 seconds, CCTV shows Person E falling over on his left side. His head is out of view but the rest of his body is clearly visible and it is clear that his legs and arms are twitching.

After a further 26 seconds, CCTV shows him rolling onto his front and lying face down on the mattress. His head is still out of view but his legs and arms are still twitching slightly.

After 90 seconds, CCTV shows the twitching stops and at 7.17pm, 53 seconds, a CDO enters the cell and checks Person E.

At 7.19pm, 11 seconds, the CDO returned to the cell and checks him again.

After 28 seconds, the custody sergeant, accompanied by another officer, enters the cell and are seen to commence CPR without the protection of a face barrier.

At 7.21pm another officer summons an ambulance and resuscitation continues until the ambulance crew arrive at 7.26pm, 9 seconds. Despite continued attempts

Person E was unable to be resuscitated and at 8.29pm the force medical examiner pronounced life extinct at Barry Police Station.

A wrap of amphetamine was subsequently recovered from the deceased man's clothing concealed between his jeans and boxer shorts.

The post-mortem examination was inconclusive and subsequent hair analysis indicated that the deceased had a history of consistent and repeated amphetamine use in the two months preceding his death. Further, that this was in the top five per cent in concentration levels.

There was also a trace of MDMA (also known as Ecstasy). Subsequent blood sample analysis indicated trace alcohol (approx 2 millilitres per 100) and amphetamine present at a concentration of 0.60 micrograms/millilitre.

The toxicologist stated: "This amount of amphetamine is consistent with high doses and lies towards the lower end of a range encountered in fatalities attributed to it."

Following further investigation and research, the Forensic Science Service (FSS) commented: "it is possible that the absence of significant amounts of alcohol in the blood was a major factor in his death."

Tests were carried out for B-hydroxybutyrate which is a marker for impairment of metabolic function due to low alcohol content in the blood of chronic alcohol abusers. The FSS commented: "the concentration of this present in the blood is somewhat elevated over that necessary encountered in life. B-hydroxybutyrate concentrations greater than 500 micromoles per litre are regarded as elevated and suggestive of a metabolic dysfunction known as ketoacidosis. This can prove fatal if left untreated and can result in hypoglycaemia. Common signs that this condition is developing include nausea, vomiting, abdominal pain, and on occasions fitting."

"In the absence of any other explanation for the death of Person E the elevated concentration of B-hydroxybutyrate coupled with low concentrations of alcohol and acetone provide support for the view and alcoholic ketoacidosis was a factor in his

death. The threat posed by this condition may have been enhanced by amphetamine.”

The Home Office Pathologist reviewed his findings on submission of the above evidence and concluded that the cause of death was chronic alcoholism and pneumonia.

There is no evidence to suggest that any members of South Wales Police staff were negligent in their duties in relation to the deceased’s arrest and detention.

No Regulation 9 notices were issued.

### **Recommendations**

- The condition “ketoacidosis” and its cause must be of major consequence for all police forces. On a daily basis there are a number of individuals taken into custody that would fit the profile of the deceased. Awareness needs to be raised nationally with all police staff and forensic medical examiners who come into contact with persons who are detained in custody who fit the profile similar to that of the deceased. South Wales Police have agreed to raise this nationally through the Association of Chief Police Officers
- A review of custody CCTV to be undertaken regarding the use of multiplex screens which were too small for custody staff to notice the movements of the deceased in the cell
- CCTV footage to be used as future training aid on Custody Officer and Death in Custody courses where good practise can be highlighted
- Three officers were recommended for acknowledgement from the Divisional Commander
- Two officers were recommended for Chief Constable Commendations.

## **6. Case Study 6**

## **IPCC supervised investigation**

### **Brief summary of incident**

At 10.46am on Wednesday 18 January 2006 Person F was arrested for being drunk and incapable. He was taken to Fairwater Police Station and kept in custody overnight. At 9am on 19 January Person F was taken to Cardiff Magistrates Court and placed in a cell. He was discovered unconscious and conveyed to hospital where he was certified dead at 11.03am that day.

A subsequent post-mortem established that the cause of death was natural causes.

Person F was 55 years-old at the time of his death and he resided at a Cardiff City Council homeless hostel.

Person F had a long history of alcohol abuse and depression and in previous years had attempted suicide. His medical records described him as a 'chronic alcoholic.' He was known to the police and had seven previous convictions. One was for a breach of the peace and six for being drunk and disorderly.

Person F was seen by two police officers on Wednesday 18 January 2006 lying face down on the ground on a central traffic island with his legs in the roadway. He was discovered with an injury to the back of his head, was conscious but smelt strongly of alcohol and urine and was clearly intoxicated.

The officers requested an ambulance to assess his medical condition. On examination the cut to the back of his head was found to be a small graze and he did not receive any further medical assistance or hospitalisation. Person F was unable to furnish the police with any home address details and was incapable of taking care of himself. He was subsequently arrested for being drunk and incapable and conveyed to Fairwater Police Station, Cardiff, where his detention was authorised.

At 11.39pm the same day Person F was charged and kept in custody to appear before the next available court the following day.

At 9.09am on 19 January 2006 Person F was released from Fairwater Police Station into the custody of Reliance Security for escort to Cardiff Magistrates Court complex.

He was placed in a cell at the court and checked regularly. Person F was discovered at 10.25am to be unresponsive and blue in the face. An ambulance was immediately summoned and took him to hospital where, despite resuscitation attempts, he was pronounced dead at 11.24am.

The subsequent investigation established that the cell buzzer in the cell that Person F had been placed in at the Police and Magistrates Court cells was not working and this was immediately brought to the attention of the Clerk to the Justices. This fault was immediately rectified.

No other recommendations were made following a comprehensive investigation. No concerns were raised over the conduct of any individual.

## **7. Case Study 7**

### **IPCC managed investigation**

#### **Brief summary of incident**

Person G, a homeless Portuguese national, was arrested for being drunk and incapable at Cardiff central bus station on the morning of 19 January 2006. He was naked from the waist down and only had socks on his feet. He was taken into custody where authority for his detention was given. A risk assessment entered into the custody record indicates that the only concern identified by the custody officer at the time was his drunkenness. He was monitored every 30 minutes in line with Police and Criminal Evidence Act codes of practice. Investigations reveal that the custody officer had prior knowledge of this man and his condition; he was homeless, dishevelled, and possibly suffering from a mental illness. He had recently served three months imprisonment, was known to social services and had been examined in the past by mental health professionals. No action was taken in relation to these issues during his time in custody and no doctor was called to examine him. He was given a meal during his time in police detention and a dry pair of trousers, his own being wet when arrested. His wet clothing was bagged and stored but not dried and was returned to him on his release from custody, still wet, in plastic bags. Approximately 12 hours later the police released him without any action taken for the offence of drunkenness, nor was any attempt made to contact social services or mental health professionals. He was given a pair of foam 'slippers' by custody staff which he retained. A further 12 hours later he was found dead in a local park, only some 600 yards from the Cardiff custody centre from which he had been released, his wet clothing still in police property bags beside him.

The ensuing police investigation focused on a number of areas including:

- The cause of death of Person G
- His arrest on 19 January 2006
- Booking into custody on 19 January 2006
- His treatment and care while in custody
- His release from custody
- Training
- Any conduct issues arising from this incident and recommendations.

At the time of his release from custody the weather conditions were clement but turned inclement during the night. The cause of death of Person G was provided by a Home Office pathologist and was given as: 'It is my view that death was most likely a result of coronary artery atheroma.'

A great deal of consideration was given to hyperthermia being a causal factor in the death as he was sleeping rough in freezing conditions, but this has been ruled out by the pathologist.

Since the arrest of Person G for being drunk and incapable, South Wales Police policy has changed and there is now clear direction to police officers that persons found drunk and incapable must receive suitable medical attention as they do not belong in a police cell.

The investigation highlighted confusion over which of the two custody sergeants actually booked Person G into custody and who actually authorised his detention; each claimed it was the other, while the custody detention officer claimed she had booked him into custody and that a sergeant authorised detention although he had not signed to say so.

The investigation also highlighted problems with the CCTV system in operation at the Cardiff Custody Centre. There are two CCTV tapes that have recorded the coverage of Person G's detention. One camera is located in the cell complex corridor and the second is located at the custody desk. The first tape shows the correct date although the clock is running 30 minutes early. The second tape shows the correct date, although the clock is running one hour and 51 minutes late. The quality of both recordings is poor.

There was also a failure in this case to provide Person G with treatment and care in accordance with the Police and Criminal Evidence Codes of Practice and whether a force medical examiner should have been called to examine him.

The investigation also established that a custody sergeant had entered on the custody record that he had provided Person G with his rights prior to him being released from custody and had cautioned him for an offence of drunkenness when this was not the case. A number of recommendations arose during this investigation:

- That the current policy on persons found drunk and incapable is monitored to ensure compliance
- That sergeants A and B receive written warnings for failing to adequately control and supervise detainees and staff within the custody unit
- That the policy in relation to intoxicated detainees is amended to state: “if an intoxicated detainee has not recovered from intoxication after four hours in detention the custody officer must call the police surgeon to seek advice.”
- That sergeant C receives a written warning for failing to properly administer Rights and a Caution to Person G
- That South Wales Police seek to give guidance to custody officers in respect of withholding Rights to intoxicated detainees with an emphasis that it should only be in rare cases that Rights are withheld due to intoxication
- Stocks of suitable clothing are stored at custody suites for issue to detainees that can be deemed to meet certain needs of warmth, comfort and weather proofing
- That South Wales Police in conjunction with other organisations seek to produce a leaflet containing information on hostels and homeless shelters which could be given to homeless people upon their release from custody
- That a review is conducted of custody training to ensure that not only are custody officers suitably trained but that adequate refresher training is provided at suitable intervals - perhaps every three or four years
- Suitable systems of supervision are also put in place to monitor custody records to ensure compliance with the codes of practice and South Wales Police policies
- The Custody Services Unit considers upgrading the CCTV system in order to enhance protection for detainees, officers and other visitors.

## **8. Case Study 8**

### **IPCC independent investigation**

#### **Brief summary of incident**

At 1.42pm on 7 March 2006, police were called to Charles Street, Cardiff, following reports from members of the public concerning a male person collapsed on a bench.

Police attended the scene and discovered 41-year-old Person H, of no fixed abode, sat upright on a bench and who did not respond to verbal commands and was unable to stand unaided. He was clearly intoxicated and had urinated in his clothes. The officers arrested him for being drunk and incapable and he was taken to Cardiff Central police station, where his detention was authorised.

Person H was known to the police and had Police National Computer (PNC) warning markers stating he was an alcoholic and suffered from epilepsy. Due to his drunken condition he was taken straight to a cell before being searched.

No force medical officer was called to examine him and he was placed on 30 minute checks. This was not in compliance with South Wales Police custody procedures which instruct a 15 minute review for severely intoxicated detainees. A policy change had been recently circulated to staff by email, which the custody sergeant claimed not to have seen.

Person H remained in custody throughout the night with 30 minute checks being undertaken. At 6.26am on Wednesday 8 March 2006 he was discovered fitting in his cell and an ambulance called. He was taken to hospital and placed on a ventilator. Although initial reports from the hospital were that Person H was not expected to survive, he did make a full recovery and in fact discharged himself from hospital on 9 March 2006.

The subsequent investigation highlighted a number of issues, including the lack of appropriate risk assessment - the custody sergeant authorised detention but did not ask any questions at any time during the detention of Person H in respect of medical history and medication etc. The PNC warning regarding epilepsy appears to have

been disregarded and no doctor was summoned to examine Person H during his period in custody.

Issues were also identified with the CCTV system in operation at Cardiff Central Custody Centre. The CCTV tapes were found to be extremely poor quality. The tape covering the cell that Person H was placed in was 67 minutes behind real time and the tape covering the custody desk was 78 minutes ahead of real time. Both showed the date as 27 September 2003, over two years out of date.

The investigation also established that there were inaccurate entries entered on the custody record with both the custody sergeant and detention officer stating Person H had been checked and “all was in order,” when in fact he had left custody and had been taken to hospital.

As a result a number of organisational recommendations were made to South Wales Police in addition to misconduct matters:

- It is recommended that patrol officers be reminded of their duty to record the reasons for and results of PNC checks in accordance with the Data Protection Act 1998
- It is recommended that immediate action is taken to ensure that the CCTV system is working correctly and that the images produced are fit for purpose
- It is recommended that South Wales Police consider the methods used to effectively communicate major policy change to relevant staff. Email alone may not reach all relevant personnel in time.

## CONCLUSIONS

In all but one of the cases detailed in this report, the individuals arrested by South Wales Police suffered from alcohol or mental health issues and could be considered as belonging to some of the most vulnerable groups in society. Five of the individuals were of no fixed abode - one of whom was residing in a hostel for the homeless. None of the cases involving death could reasonably have been foreseen or prevented. It is recognised that detention in police cells is no place for individuals who are from some of the most vulnerable groups in society and suffering from mental health or drug-related illnesses.

However, the comprehensive investigation that resulted from each of these cases, has highlighted several issues and recommendations have been made in a number of areas which if implemented could help prevent future deaths or adverse incidents arising from contact with police.

This of course is true not just for South Wales Police but for the police service in general and for the wider Criminal Justice System as a whole with Health and Social Services playing a key role.

ACPO and the Home Office have recently produced guidance for police forces regarding the appropriate care and treatment of detained persons. The 'Safer Detention and Handling of Persons in Custody' guidance was developed throughout 2005 and the IPCC actively took part in the consultation process. The final guidance was agreed in January 2006 and includes a chapter specifically on dealing with deaths and adverse incidents in custody, with information on how lessons should be learnt.

During 2005 a new multi-agency forum for preventing deaths in custody was established which aims to share best practice and help reduce deaths across all custodial settings. The forum is made up of Healthcare and Criminal Justice professionals and brings together representatives from 14 organisations across government, police, prisons, coroners and the independent sector. It has been set up

in response to the Parliamentary report into deaths in custody by the Joint Committee on Human Rights, which recommended the need to establish a multi-agency expert task force which would focus around learning arising from custody deaths.

It is fair to say that South Wales Police have been quick to seize on opportunities for learning arising out of the recommendations made in each of the investigations detailed in this report and have embraced the guidance detailed in the *Safer Handling and Detention of Persons in Police Custody* publication, acknowledging in September 2006 that the publication will 'set the standard for the future provision of custody facilities and will be the main work stream for custody services over the next 18 months.'

As a result of the two deaths following a period of detention at Cardiff Central Police Station in January 2006 and a third near miss case in March 2006, South Wales Police have revisited and made a number of policy changes in key areas. These are detailed in an internal memorandum dated 6 September 2006. The content of which is summarised below:

The changes include a revised protocol on the detention of drunk and incapable detainees. This now means that all drunk and incapable detainees are escorted directly to hospital for early advanced medical care, prior to them being brought to a custody unit. If after release from hospital they are brought to a police station for detention, the protocol outlines mandatory management actions and stipulate that a health care professional must be consulted to advise on a package of care.

The acute problem with drunk and incapable detainees was such that due to the immediacy of the actions required no liaison with the five NHS Trusts was possible. As a result numerous complaints have been received and there have been incidents where Accident and Emergency departments have refused to assess drunk and incapable prisoners. Conversely there have been occasions where drunk and incapable prisoners have been admitted to hospital due to the seriousness of their condition.

South Wales Police have now written to all the Trusts and have been provided with the necessary background information as to the catalyst and requirement for the drunk and incapable protocol. No agreement has yet been reached and significant work is anticipated in this area. This type of partnership work is a key feature of the *Safer Detention and Handling of Persons in Custody* guidance (SDHP). The acute lack of a co-ordinated inter-agency strategy is seen as potentially placing lives at risk. On 11 May 2006, South Wales Police arranged a multi-agency conference at Bridgend with key partners in order to discuss the lack of a co-ordinated strategy in dealing with vulnerable groups throughout South Wales. The conference was poorly attended and delegates were not of a sufficiently high strategic level for progress to be made.

In addition, South Wales Police have set up a project team to address recommendations arising from the SDHP document and work commenced on the various work streams in October 2006.

As a result of the Person G case, awareness has been raised regarding pre-release risk assessment, a document detailing action to be followed as part of the risk assessment had not previously been widely circulated but this has now been published and is available to all staff.

A stock of clothing including shoes has now been purchased and is available throughout all South Wales Custody Suites. These clothes are specifically for homeless persons whose clothing has been soiled or disposed of.

The force has also linked in with partner agencies and has engaged with Social Services. Homeless charities in Cardiff have been contacted and they have agreed to offer beds to homeless persons released from custody, subject to availability. A similar scheme is being developed in conjunction with Veritas in Swansea. Contact details for the relevant support agencies are available on the Custody Services website.

The provision of health care professionals was out-sourced to Veritas Management Ltd on 15 May 2006. The force has experienced difficulties with this provision since

its inception. These have been mirrored in other force areas that also out-sourced its medical provision. An improvement plan was agreed and an improving picture was evolving. Since its inception the medical provision provided by Veritas was widely accepted as providing an improved service to custody offices. It is therefore unfortunate that due to the difficulty in maintaining a comprehensive medical service that Veritas found itself in a position that it could no longer provide this service. South Wales Police were therefore forced to return to the previous system of using a small number of doctors and nurses to provide a medical response. In addition, a pilot scheme has been introduced in Swansea custody centre where a local mental health team nurse is located within the custody suite. This is already proving beneficial with the nurse highlighting a significant number of individuals who are entering custody with mental health-related needs that were previously undiagnosed. The nurse is now able to assist with case and risk management during detention and can also ensure appropriate referral following release from custody.

South Wales Police has also updated the custody officers' law course, which has also been extended from one week to two weeks in duration. This course is mandatory for officers before they undertake the role of custody sergeant. This course has been revised and is now compliant with the SDHP doctrine. The course includes specific reference to the care of intoxicated detainees as part of the death in custody input. A similar package exists for the civilian detention officers. Both courses emphasise the importance of thorough risk assessments and the need for detailed custody log entries.

**It is recommended that in addition to the existing training courses mechanisms should be put in place to ensure that all custody staff receive regular updates in respect of changes in law, policy and procedures.**

In addition, guidance on the detention of detainees suffering from alcoholic ketoacidosis has also been produced. This followed from an adverse incident in March 2006 and recognises that the management of these detainees is especially difficult as the longer they remain in custody the more of a risk they become.

Previous investigations, which were undertaken, managed or supervised by the Independent Police Complaints Commission, highlighted the fact that custody staff were claiming that they were unaware of changes or updates in policy which impacted on their duties. This was previously communicated to staff by general e-mail and fax. However, this procedure has been re-visited and all custody officers have received a hard copy of the latest guidance together with a flow chart which has been issued against signature. Detention officers have received the same documentation and in addition laminated posters have been widely circulated to all custody offices.

**While the force should be congratulated on being quick to act on areas highlighted from the adverse incidents detailed in this report, Senior Managers should ensure that the ongoing work is finalised and all aspects of the new initiatives become included in force policy.**

One area of concern which has been highlighted to South Wales Police by the IPCC Commissioner Tom Davies on numerous occasions is the issue over CCTV provision in South Wales Police custody centres. In particular, a number of investigations have highlighted poor quality, inadequate camera coverage, inadequate monitoring facilities, no audio, and significantly CCTV systems showing the wrong time and date.

Four of the eight investigations mentioned in this report alone highlighted deficiencies in the CCTV systems in operation within the custody centre concerned. Other cases being independently investigated, managed or supervised by the IPCC outside of this review period have also identified similar deficiencies.

Of particular concern are the investigations where the CCTV system show the wrong time and date, for example, in the cases listed below the timings of the CCTV system recorded the following:

Person G investigation: In addition to the poor quality of the recordings, inaccurate timings were found, with one tape indicating 30 minutes earlier than actual time, while the second tape was showing one hour and 51 minutes ahead of actual time.

Person H investigation: Arrested on 7 March 2006. Both tapes indicated that the date was 27 September 2003, one tape was 67 minutes behind real time, the second tape was 78 minutes ahead of real time. Again poor quality was an issue.

A recent investigation following an incident in the summer of 2006 demonstrated that the CCTV problems were still persisting. Examination of the CCTV system showed the tape recording 78 minutes ahead of real time. Again poor quality of recordings was evident and this impacted on this particular investigation where good quality recordings could have assisted in proving/disproving allegations being made against custody staff.

In each of the above investigations South Wales Police Professional Standards Department (PSD) were informed of the deficiencies as part of fast-track actions. In turn, the Head of Professional Standards brought this to the attention of the force's Head of Custody Services, writing on 6 September 2006.

On 17 November 2006, South Wales PSD undertook spot checks on eight custody centres throughout the force area with CCTV installed, in order to check the accuracy of the recordings. Only at two custody centres, Merthyr Tydfil and Aberdare, were the systems found to be operating correctly. Time discrepancies were found at the other six custody centres ranging from four minutes to 85 minutes behind actual time. The CCTV system at Bridgend showed the date as 1 January 1996, while the CCTV system at Cardiff was found not to be recording due to a machine fault - see Appendix D.

This has highlighted the systemic failure in CCTV monitoring and recording systems throughout the South Wales Police area and detracts from the excellent work which has been ongoing in other areas of prisoner handling and which has been highlighted in this report.

Should another tragic incident occur in a custody centre where timings are found to significantly deviate, the force could easily find themselves trying to justify to family members and ultimately to a Coroners Court the integrity of recordings if allegations

are understandably made that tapes have been tampered with due to differences in times and dates.

IPCC Commissioner Tom Davies as part of his regular Guardianship meetings with the Chief Constable of South Wales and ACPO leads has brought this matter to their attention on a number of occasions. In addition, he has also written to the force's Head of Professional Standards, on 22 January 2007 expressing his frustration that despite raising the problems on numerous occasions they still persist, with no remedial action having appeared to have been taken. It is the Commissioner's intention to now deal with managers responsible for overseeing the CCTV systems in custody centres under the Police Misconduct Code should any similar re-occurrences be highlighted in future investigations.

While it is accepted that upgrading the CCTV systems in the custody centres will involve a significant cost implication for the force, simple measures can be introduced to ensure an improvement in recording quality and timing accuracy, similar to the daily and weekly checks that are currently undertaken for ensuring the integrity of intoximeters situated in custody centres.

**It is recommended that a system of checks be introduced for CCTV systems in operation in custody centres with custody sergeants signing a daily register to ensure accuracy of the time shown on recordings and that tapes are regularly changed and recording heads regularly cleaned. This will ensure accuracy of timings and help improve quality of recordings.\***

\* Since compiling this report South Wales Police have produced a custody services instruction policy for CCTV systems which includes instructions to staff on the checking of the CCTV systems at the commencement of each shift. This policy was implemented on 1 March 2007. In addition, South Wales Police have now invited tenders for the replacement of CCTV systems within custody centres. New procedures are also in place for CCTV maintenance staff, with response times being introduced for repairs to equipment.

South Wales Police have recently produced a draft custody services procedures manual detailing the action to be taken by custody staff in the event of an adverse incident. An adverse incident within the custody environment is deemed as “any incident which results in, or could have resulted in, the serious illness, injury or self-harm to a detainee.”

This is a comprehensive document detailing check lists of primary and secondary actions, referral to the Force Professional Standards Department and IPCC, investigative standards, fast-time and slow-time learning, which is all overseen by an incident monitoring group.

In addition, South Wales Police have again recently produced a draft custody services procedure manual detailing pre-release risk assessments. Again this is a comprehensive document which will assist in identifying, assessing and reducing continued risks associated with a detainee at the time of their release. The aim of the pre-release risk assessment is to prevent detainees after release:

- Harming themselves or others
- Becoming ill due to their condition
- Or being placed into circumstances where there is foreseeable risk that they will come to some harm.

A final area of on-going work being undertaken by South Wales Police is support provision for homeless detainees. As previously stated five out of the eight cases referred to in this report involved homeless persons. The majority of homeless individuals who will come into police custody will be as a result of committing vagrancy offences, alcoholic related offences or as a result of class A drug misuse. A Drug Intervention Programme is currently being established throughout the South Wales Police area with a view to proactively diverting offenders out of crime and into treatment. It is however recognised that homeless people have a low engagement rate with existing drug and alcohol services.

The force has also been in contact with Mr Earl Smith, the Welsh Assembly lead for homelessness issues, regarding referral pathways on a Wales-wide basis which

South Wales Police could potentially access. An initial scoping exercise established that voluntary sector providers were unable to provide a 24 hour support network capable of providing suitable support for homeless people leaving detention.

The force are keen to progress suitable protocols with local authorities for such individuals, although it is recognised that funding streams will be a major issue in the development of providing an enhanced duty of care provisions to those persons classed as homeless whilst in or leaving custody.

**The IPCC are keen to assist South Wales Police develop protocols with partner agencies to help reduce the incidences of deaths in or following police detention.**

**It is recommended that a multi-agency forum be established on a force-wide basis, similar to the national multi-agency task force discussed earlier in this report, which will assist in a co-ordinated approach in helping individuals from vulnerable groups who should not be detained in police cells**

**It is further recommended to assist in this initiative that South Wales Police undertake a gap analysis in the provision of interagency working in this area.**

The successful initiatives that have been undertaken in the various areas of the Force and could be considered for wider use include:

- A revised protocol on the detention of drunk and incapable detainees
- Pre-release risk assessments for detainees
- The introduction of Mental Health Team nurses in custody centres
- Guidance on detention of detainees suffering from Ketoacidosis
- Support provision for homeless detainees.

As part of this review, and in order to identify good practice, IPCC commissioner for Wales Tom Davies wrote to the Chief Constables of the other Welsh Forces enquiring about any partnership agreements or forums that currently exist in relation to vulnerable groups in their respective Force areas - Appendix E.

The purpose of this report is to establish if there were any re-occurring themes in the incidents examined which could be brought to the attention of South Wales Police and other agencies for remedial action to be taken and perhaps assist in preventing similar incidents from occurring in the future.

The report did not include a review of all South Wales Police custody working practices but has served to highlight not only the many excellent initiatives that have been undertaken by the Force but also to highlight where improvements could be made.

The recommendations made in this report are not a criticism of South Wales Police but serve as a platform for future working with partner agencies to build on the progress that has already been witnessed in the handling of detainees throughout South Wales.

The Force have been quick to seize on opportunities and have recognised the need for community and partnership engagement in its quest for excellence in this area , recognising there is much more that could be done with the assistance of partner agencies.

The IPCC and South Wales Police have worked together in producing this report which it is hoped will serve as a catalyst for South Wales Police and its partners to build on the improvements seen so far.

## Deaths in Police Custody 2002/03 to 2005/06

	2002/03	2003/04	2004/05	2005/06
Avon & Somerset	1	0	4	1
Bedfordshire	1	0	0	0
Cambridgeshire	0	0	0	0
Cheshire	1	0	1	0
City of London	0	0	0	0
Cleveland	0	1	1	0
Cumbria	0	0	0	0
Derbyshire	0	2	2	1
Devon & Cornwall	0	0	1	3
Dorset	0	2	1	0
Durham	0	0	0	0
Dyfed Powys	0	0	0	0
Essex	1	0	0	3
Gloucestershire	0	0	1	0
Greater Manchester	2	2	3	2
Gwent	0	0	0	0
Hampshire	1	0	0	0
Hertfordshire	0	0	1	0
Humberside	0	0	0	0
Kent	0	1	1	1
Lancashire	1	2	0	1
Leicestershire	0	0	0	0
Lincolnshire	0	1	1	0
Merseyside	1	0	1	0
Metropolitan	9	6	5	6
Norfolk	0	0	1	0
North Wales	0	1	0	1
North Yorkshire	2	0	0	0
Northamptonshire	0	2	0	0
Northumbria	1	3	1	1
Nottinghamshire	0	2	0	0
South Wales	1	0	4	0
South Yorkshire	0	0	2	2
Staffordshire	0	0	0	1
Suffolk	0	0	0	1
Surrey	0	0	0	0
Sussex	3	0	0	2
Thames Valley	3	0	1	1
Warwickshire	0	0	1	0
West Mercia	0	1	0	0
West Midlands	2	2	0	1
West Yorkshire	0	0	3	0
Wiltshire	0	1	0	0
<b>Total</b>	<b>30</b>	<b>29</b>	<b>36</b>	<b>28</b>

### Definitions of Deaths During or Following Police Contact

Deaths of police personnel or incidents which involve off-duty police personnel are not included under these categories.

Road Traffic Fatalities includes deaths of motorists, cyclists or pedestrians arising from police pursuits, police vehicles responding to emergency calls and other police traffic-related activity.

This would not include the following:

- \* Deaths following a road traffic incident where the police have attended immediately after the event as an emergency service.

Fatal Shootings includes fatalities where police officers fire the fatal shots.

Deaths In or Following Custody includes deaths of persons who have been arrested or otherwise detained by the police. It includes deaths which occur whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

This would include the following:

- \* Deaths which occur during or following police custody where injuries which contributed to the death were sustained during the period of detention.

- \* Deaths which occur in or on the way to hospital (or other medical premises) following or during transfer from police custody.

- \* Deaths which occur as a result of injuries or other medical problems which are identified or develop while in custody.

- \* Deaths which occur while the person is in police custody having been detained under the Mental Health Act 1983 Section 136 or other legislation.

This would not include the following:

- \* Deaths (including suicides) which occur following release from police custody except those which meet the criteria outlined above.

- \* Deaths of individuals who have been transferred to the care of another agency and subsequently die whilst in their care.

Deaths During or Following Other Police Contact includes deaths where a link can be established between the police contact and the death, and which did not involve arrest or other detention.

This would include the following:

- \* Deaths which occur after police are called to attend a domestic incident which results in a fatality.

- \* Deaths which occur while a person is actively attempting to evade arrest. This includes instances where the death is self-inflicted.

- \* Deaths which occur when police are in attendance at a siege situation, including where a person kills himself or someone else.

This would not include the following:

- \* Deaths of those who have attended police stations as visitors, witnesses or in a professional capacity.

- \* When police attend an incident where a person receives, or has received fatal injuries, either self-inflicted or otherwise. For example, when the police have been called to a suicide attempt and there are no concerns about the conduct of the officers.

- \* Deaths which occur in a police vehicle when that vehicle is being used in lieu of an ambulance to transport a person to a medical facility.

## Appendix C

	Person A	Person B	Person C	Person D	Person E	Person F	Person G	Person H	Person I
Mode of Investigation									
Age									
Gender									
Ethnic Origin									
Health Status									
NFA									
Criminal record									
PNC Warning Markers									
Reason for arrest									
Date of arrest									
PNC Check completed									
Known involvement with statutory bodies									
Transportation to station									
Location of station									
Police Staff - arresting officers									
Risk Assessment conducted									
Taken straight to cell									
FME requested									
Detainee checks completed appropriately									
Period of detention									
Regularity of reviews									
CCTV available and location									
Quality of CCTV									
Police Staff - custodial									
Civilian Staff									
Circumstances around death									
Attempts at resuscitation									
Post mortem - cause of death									
Coroners comments post inquest									
Recommendations from investigation report									
Status of criminal/misconduct issues									
File sent to CPS									

**FINDINGS OF PSD 'SPOT CHECKS' SWP CUSTODY SUITES  
17/11/2006 RE. CCTV EQUIPMENT**

<b>Custody Suite</b>	<b>Visited by</b>	<b>Recorded Time</b>	<b>BST</b>	<b>Time Discrepancy</b>	<b>Any Observations</b>
Barry	Investigative Assistant	08:42	09:42	-60 minutes	Custody Sgt on loan from Cardiff for the day. Could not assist.
Bridgend	Detective Inspector	09:56	10:00	- 4 minutes	Date shown on CCTV 01/01/1996
Swansea	Detective Inspector	08:56	10:00	-64 minutes	
Neath					No CCTV
Port Talbot					No CCTV
Merthyr Tydfil	Investigative Assistant	10:00	10:00		
Aberdare	Detective Inspector	10:00	10:00		
Pontypridd					No CCTV
Ton Pentre					No CCTV
Rumney	Detective Inspector	10:49	11:52	-63 minutes	
Fairwater	Investigative Assistant	10:00	09:45	+15 minutes	
Cardiff Central	Detective Inspector	10:00	11:25	-85 minutes	CCTV not recording – machine fault.

### OTHER WELSH FORCE INITIATIVES

Dyfed-Powys Police, together with the other Welsh forces, circulate details of any adverse incidents occurring within the custody environment to ensure the widest learning and help prevent future incidents. In addition, all the Welsh forces are represented at the Welsh Custody Forum which is also attended by the IPCC and lessons learned and good practice identified.

North Wales Police have introduced protocols in respect of the transfer of persons under Section 136 of the Mental Health Act and these have been agreed between them and the various Health Trusts. In addition, work is in progress to finalise a protocol between the Police, Health Service and other agencies in relation to detainees who are in need of treatment while in custody who may be violent, detainees who may have swallowed drugs and detainees with health problems.

In addition NWP has put in place arrangements with other agencies to share information concerning vulnerable groups. Prolific and persistent offender officers are based in all divisions, providing support to vulnerable offenders who commit volume crime in attempts to curb re-offending and reduce the incidences of them being brought into custody.

The Force is also in the process of developing protocols with the North Wales Police custody units and local community mental health teams in relation to mentally disordered offenders. The North Wales Mental Health Forum was formed in 2005 and includes representatives from the Prison Service.

There is also a Protection of Vulnerable Adults forum in place, which is led by social services, which meets quarterly and involves the three health trusts in North Wales.

Finally, North Wales, have three Trust-employed “Care Program Approach Coordinators” who receive details of individuals coming to the attention of police negotiators in suicide cases and undertake the necessary follow up care.

Gwent Police, like the other Welsh Forces, circulate details of adverse incidents throughout the region as well as highlighting them at their Criminal Justice Departmental Health and Safety meetings. Minutes from these meetings are made available to all staff via the Force intranet site.

At a more strategic level the Force are also involved in the Gwent Mentally Disordered Offenders Working Group that meets regularly to discuss issues around the detention and treatment of such persons. This is a multi-agency group and involves representatives from the Gwent National Health Trust, the five local Health boards, members from the voluntary sector, staff from independent hospitals, the Crown Prosecution Service and the Probation Service. This main group has a sub group of professionals who have been tasked with resolving any issues that arise regarding failures in the processes or procedures between agencies. Two financial bids have been made to the Welsh Assembly Government under the *Making the Connection* fund in order to support the on-going work around mental health.

Gwent Police have also formed a working group regarding persons detained under Section 136 of the Mental Health Act with the aim of developing protocols that will assist in dealing more effectively with this category of detainee. The Force through training and information sharing are attempting to reduce the number of individuals detained under S. 136 and are reinforcing the need for those persons who are detained under such powers to be dealt with appropriately and in the right environment. To this end Gwent Police are currently in discussion with the Area Emergency Duty Team of Mental Health Social Workers with a view towards setting up a staff “exchange” scheme. The intention is to encourage Gwent Polices staff to undertake an attachment working alongside colleagues from Social Services to develop an understanding and appreciation of each others role.