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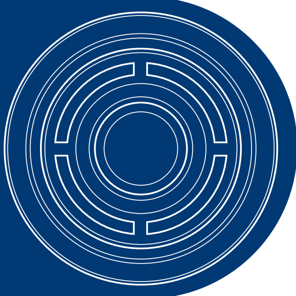
POLICE CUSTODY

The detention of persons in police custody in Northern Ireland

March 2016

The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
a better justice system for all



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The detention of persons in police custody in Northern Ireland

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List of abbreviations

AFMONI	Association of Forensic Medical Officers Northern Ireland
APP	Authorised Professional Practice
ASIST	Applied Suicide Intervention Skills Training
CCTV	Closed-circuit television
CDO(s)	Custody Detention Officer(s)
CJI	Criminal Justice Inspection Northern Ireland
DAC	Direct Award Contract
DHSSPS	Department of Health, Social Services and Public Safety
DoJ	Department of Justice
FMO(s)	Forensic Medical Officer(s)
GMC	General Medical Council
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
Niche RMS	Niche Technologies Records Management System
NICTS	Northern Ireland Courts and Tribunals Service
NIPB	Northern Ireland Policing Board
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
OPONI	Office of the Police Ombudsman for Northern Ireland
PACE	Police and Criminal Evidence (Northern Ireland) Order 1989
PPE	Personal Protective Equipment
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
TACT	Terrorism Act 2000
UN	United Nations

Chief Inspectors' Foreword

Police custody suites are an area of significant risk for the Police Service of Northern Ireland, both at a corporate and individual level. Managing and caring for detained persons, many of whom will be drunk, drugged, aggressive, in crisis, out of control and in need of protection, often from themselves, is the constant challenge for those working within the custody environment.

The role of a Custody Sergeant is particularly complex and demanding. These Officers are required to assess and manage the risks presented by a detained person, consider the evidence to support their continued arrest and authorise either their detention or release. In addition they are required to adjudicate between the competing needs of investigators, prosecutors and defence lawyers by correctly interpreting the Police and Criminal Evidence (Northern Ireland) Order 1989 codes of practice, legal powers and ensure human rights compliance. It is critically important that they continue to be recognised, supported and trained to deliver these duties.

This is our third report on the subject in the last six years and we are encouraged that we are starting to see some real progress towards more efficient use of the custody estate and standardisation of practice that will improve conditions for both staff and detainees, and effectively manage the risks encountered in this challenging environment.

However, more work needs to be done, in partnership with health and social care organisations, to ensure that people with alcohol and drug dependency and mental health conditions access services appropriate to their needs, rather than being brought to police custody suites. Custody personnel do not have the

requisite skills and training nor access to the levels of clinical expertise that are so often required. Alternatives must also be found to minimise the use of police cells for children except in the most serious of criminal cases.

We have made a small number of strategic and operational recommendations designed to support continued improvement in this high risk area of police activity.

This inspection was conducted by Rachel Lindsay from Criminal Justice Inspection, and Liz Colgan and Sheelagh O'Connor from the Regulation and Quality Improvement Authority.

My sincere thanks to all who contributed to their work.

Brendan McGuigan
Chief Inspector of Criminal Justice in Northern Ireland

March 2016

Glenn Houston
Chief Executive

March 2016

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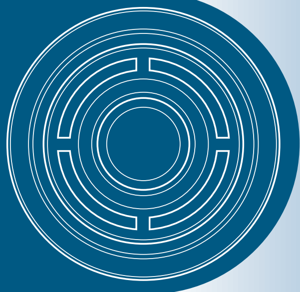

Executive Summary

This is the third report by Criminal Justice Inspection Northern Ireland (CJI) and the Regulation and Quality Improvement Authority (RQIA) on police custody in Northern Ireland. It follows a full inspection in 2009 and a follow-up review in 2013, both which are available on CJI's website (www.cjini.org). This inspection contributes to the United Kingdom's response to its international obligations under the Optional Protocol to the United Nations (UN) Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The inspection utilised a framework of Expectations which considered performance against four areas: strategy; treatment and conditions; individual rights; and healthcare. The inspection fieldwork included face-to-face meetings with a range of stakeholders, police officers and staff engaged in custody delivery and management; visits to custody suites; and a survey of detainees who had experience of being detained by the Police Service of Northern Ireland (PSNI).

Strategy

Since the previous inspections there had been greater efforts to improve the consistency of practice and service delivery across the custody suites. A team was in place to co-ordinate all aspects of custody policy and drive the changes required under the Custody 2020 Reform Programme. Whilst the PSNI had not opted to move to a centralised delivery model, as recommended by CJI in its initial report, there was evidence of actions taken to ensure

greater standardisation across the suites as well as efforts to use data to predict demand and resource requirements. The next step in this process is the embedding of a more standardised approach to custody delivery and a flexible staffing model for Custody Officers and Custody Detention Officers (CDOs). Partnerships between the Departments of Justice (DoJ) and Health, Social Services and Public Safety (DHSSPS) to deliver a Joint Health and Justice Strategy were critical to the PSNI's aims to improve the custody healthcare service and this will be kept under review. There was a focus on custody from the Northern Ireland Policing Board (NIPB), with an active Independent Custody Visiting Scheme in place, and the Custody 2020 Reform Programme featured in the Policing Plan.

Treatment and conditions

There were considerable challenges around dealing with children and young people in police custody, particularly post-charge given the lack of alternative accommodation and inconsistencies in legislation. Previous recommendations to address these had not been acted upon and there is a need to bring forward legislation to address the issues surrounding bail for young people. There was a major focus on risk assessment and management by custody staff and technology was available in most suites to assist in keeping detainees and staff safe.

Staff described the challenges of dealing with a difficult and diverse detainee population, with high levels of addiction, mental health issues, self-harm or suicidal tendencies and violence against staff. There were limited opportunities to signpost support for detainees, particularly adults, once they left the custody suite. Despite these challenges, use of force was not high with only 15% of detainees reporting that they had been restrained in the custody suite.

A rolling programme of refurbishment ensured that the physical conditions in most suites were good. Detainees were treated well in terms of their dietary, hygiene and activity needs, although this was more difficult for those who were detained longer than 24 hours.

Individual rights

Detention appeared to be appropriate, authorised and expeditious. Inspectors were advised that difficulties in progressing the investigation quickly appeared to relate to resourcing issues rather than a lack of will by investigating officers. Court cut off times on a Saturday could be difficult to adhere to but work was ongoing with the Northern Ireland Courts and Tribunals Service (NICTS) as to how alignment between police and court processes could be improved. An Appropriate Adult Scheme was in place for children and vulnerable adults which was well used and considered valuable. Similarly interpreting and translation services were provided for those who did not speak English as a first language. Detainees were well represented by local solicitors. The situation in respect of the storage and management of forensic samples was much improved but will need continued monitoring. The Office of the Police Ombudsman for Northern Ireland (OPONI) dealt with complaints arising from police custody but most of these related to treatment by arresting officers rather than the custody environment itself.

Healthcare

The delivery of healthcare in custody remained the biggest challenge and area of risk for the PSNI. The PSNI continued to utilise individual Forensic Medical Officers (FMOs) to deliver healthcare in custody suites while work was ongoing to develop a Joint Healthcare and Justice Strategy. A firm timescale is now required for the completion of an alternative

custody healthcare model. Improvements had been made to the appraisal process for the FMOs but clinical governance arrangements need further improvement. Custody staff had received some training in the area of healthcare but there was a need for further training commensurate with the role.

The domestic cleaning contract required further review and closer monitoring to improve the service and the first aid boxes required greater standardisation and checking. There was variation in the availability and use of equipment to protect staff from infection and there were still issues with the management of clinical waste and storage of medication in fridges. Infection prevention and control precautions require improvements.

Detainees were dealt with in a respectful and dignified way and reported in general being satisfied with the quality of healthcare received. The approach to records management was varied and not in line with the DHSSPS guidance for patient confidentiality which needs addressing. Provision in the custody suites for detainees with mental health and addiction issues had been withdrawn and accessing these services was a huge challenge for custody staff. Links between police and health providers need to be formalised to address this. Concerns remained over the administration of medication and storage of medication not consumed. A review of medications management should be undertaken immediately and a clear audit trail should be in place.

Strategic Recommendations

1

Inspectors recommend that the PSNI move to a more flexible, demand-led staffing model for both Custody Officers and CDOs, and that this is reflected in any future agreement for a managed service contract for CDOs *(paragraph 2.19)*.

2

Inspectors recommend that legislative reform is required in the following areas. It is recommended that the DoJ should:

- firstly; bring forward a Bail Act to implement the recommendations of the Law Commission in respect of the right to bail for children and young people to the Assembly at the first available opportunity in the new Assembly mandate; and
- secondly; bring forward changes to PACE which make provisions for alternative accommodation for children who are charged with an offence which clarify the legislative position about the detention of children and young people for Custody Officers *(paragraph 3.18)*.

3

Inspectors recommend that there is a firm timescale developed for the completion of, and the subsequent delivery of a more effective alternative custody healthcare model for police custody suites *(paragraph 5.5)*.

4

Clinical governance arrangements need to be standardised and strengthened for the FMO service across Northern Ireland *(paragraph 5.9)*.

5

It is recommended that the PSNI should urgently review its policies and procedures for the safe selection, procurement, prescription, supply, dispensing, storage, administration and disposal of medications. There should be a clear audit trail in place for the management of medications *(paragraph 5.49)*.

Inspection Report

Introduction

The need for effective and safe police custody

1.1 Dealing effectively with people who come into contact with the police is key to:

- building community confidence;
- investigating crime successfully;
- building safer and more secure neighbourhoods; and
- creating a safe working environment for staff.[1]

1.2 The OPCAT is an international human rights treaty designed to strengthen protection for people deprived of their liberty. It recognises that such people are particularly vulnerable and aims to prevent their ill-treatment through establishing a system of visits or inspections to all places of detention. The OPCAT requires that States designate a National Preventive Mechanism (NPM) to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment.[2]

1.3 In 2003 the United Kingdom ratified the OPCAT and designated its NPM in 2009. At the time of this report the United Kingdom's NPM was made up of 20 visiting or inspecting bodies who visit places of detention including prisons, police custody, immigration detention centres, children's secure accommodation and mental health institutions. The NPM is co-ordinated by Her Majesty's Inspectorate of Prisons in England and Wales (HMIP). In Northern Ireland the NPM bodies include CJI and the RQIA.

1.4 The Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE) is the primary legislation which protects the rights of the detainee in police custody. The PACE Code of Practice C[3] sets out the responsibilities of the police in respect of the detention, treatment and questioning of persons by police officers. The Corporate Manslaughter and Corporate Homicide Act 2007 was extended to cover Northern Ireland in 2012. The PSNI can therefore potentially be prosecuted for corporate manslaughter following a death in custody.

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1 Authorised Professional Practice (APP): Detention and Custody, College of Policing, April 2015, accessed online at https://www.app.college.police.uk/app-content/detention-and-custody-2/introduction/.
2 OPCAT and the United Kingdom's NPM, Her Majesty's Inspectorate of Prisons (HMIP) accessed online at https://www.justiceinspectorates.gov.uk/hmiprisons/national-preventive-mechanism.
3 At the time of the inspection PACE Codes of Practice A-H 2014 were in effect. On 1 June 2015 new codes came into operation.

1.5 The College of Policing had introduced Authorised Professional Practice (APP) in 2015 as the official source of professional practice on policing. Police officers and staff were expected to have regard to APP in discharging their responsibilities. The Guidance on the Safer Detention and Handling of Persons in Police Custody had therefore been superseded by the APP on Detention and Custody.

Background to this inspection

1.6 In June 2009 CJI published its first inspection of police custody, in partnership with the RQIA.[4] A follow-up review was conducted and published in February 2013.[5] The follow-up review found that of the 12 original recommendations, only three had been achieved, six had been partially achieved and three had not been achieved. The report commented that *'Custody services have, in general, been delivered to an acceptable standard, when compared to the criteria for assessment. However, the limited progress in respect of some recommendations, particularly in relation to the moving to a centralised model, and in achieving a consistency of service delivery across the custody estate, is disappointing.'* It was therefore confirmed that in view of the limited progress to date, CJI and the RQIA would return to this topic to conduct a further full inspection.

1.7 The inspections conducted to date have utilised a set of Expectations developed for the rolling programme of inspections of police custody in England and Wales by HMIP and Her Majesty's Inspectorate of Constabulary (HMIC). Expectations are informed by, and referenced against, the PACE codes,[6] guidance on the safe detention and handling of persons in custody (2006) and international human rights norms. They are also based on the experience of HMIP and HMIC over many years, and the contributions of a wide range of organisations and stakeholders. The use of these expectations offered a benchmark of acceptable practice across Northern Ireland and England and Wales.

1.8 The Expectations were tailored for use in Northern Ireland and agreed with the PSNI. The four inspection areas were:

- strategy;
- treatment and conditions;
- individual rights; and
- healthcare.

A copy of the Expectations used in the inspection can be found at Appendix 1, which can be viewed/ downloaded from CJI website - **www.cjini.org**.

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4 Police custody: The detention of persons in police custody in Northern Ireland, CJI 2009.
5 Police custody: a follow-up review of the inspection recommendations, CJI 2013.
6 The specific references to PACE contained in the Expectations relate to the PACE Codes of Practice C and H 2012 which were in effect in England and Wales at the time of development.

The 2015 inspection

1.9 The terms of reference for this inspection can be found at Appendix 2 (available from www.cjini.org). All appendices are accessible via www.cjini.org. In preparation for the fieldwork CJI conducted a survey of prisoners who had recently been committed to Maghaberry Prison (adult males), Hydebank Wood Young Offenders' Centre (young people aged 18 to 21 years, Ash House Prison (adult females) and the Woodlands Juvenile Justice Centre (for children aged 17 years and under). Prisoners were asked a series of questions about their most recent experience of police custody, prior to being remanded into prison custody. Questions queried the physical conditions of the cell, provision of food, drinks, clothing and bedding, safety and treatment by custody staff, access to legal representatives and healthcare professionals, and background details of the detainee themselves. A copy of the questionnaire and the results of the survey compared to those collected for the 2009 report can be found at Appendices 3 and 4[7] both of which can be viewed or downloaded from the CJI website www.cjini.org.

1.10 Meetings were held with a number of stakeholders in advance of the inspection including Senior Managers from the two prisons and the Juvenile Justice Centre as outlined above, the OPONI, Independent Custody Visitors from the NIPB Scheme and the Scheme Administrator/Manager, Mindwise (who deliver the Northern Ireland Appropriate Adult Scheme), the Northern Ireland Commissioner for Children and Young People, the Committee on the Administration for Justice and the DoJ. Relevant documentation and statistics were also reviewed.

1.11 Fieldwork was undertaken with the PSNI over a two week period in April 2015. Throughout this period Inspectors undertook unannounced visits to nine custody suites. During these visits Inspectors spoke to the Custody Officer and CDOs, as well as any cleaning staff and FMOs present. In addition, detainees in the custody suite were asked the same set of questions from the detainee survey as described earlier.

1.12 Where individuals who completed the detainee survey had provided their name to Inspectors (which was optional) and had raised concerns about their time in custody, Inspectors sought access to their custody records on the Niche Records Management System (RMS). It was possible to access eight custody records in this way which enabled a review of the details of the custody record, including the activities of the custody staff during the period of custody (for example to provide food, observations, the opportunity to shower etc.) as well as interactions between the detainee and their solicitor, the FMO, interpreters and appropriate adults where applicable. Whilst a very small sample, this afforded some insight into the treatment of these detainees during their time in custody.

1.13 Outside the custody visits, a series of one-to-one interviews and focus groups were held with a range of police officers and police staff including the Chief Officer responsible for custody, staff from the Reducing Offending and Safer Custody Branch of the Service Improvement Department, a Custody Superintendent, Custody Inspectors, Custody Officers, Detectives, CDOs, FMOs, staff from Health and Safety and Estates and Training Branch.

7 Questions have only been compared where the same/similar question was asked in the survey in the 2009 report.

PSNI custody provision in 2015

1.14 At the time of inspection the PSNI had the following custody provision across the estate as outlined in Table 1:

Table 1: Cell provision across PSNI custody suites

Custody suite	Location/policing district	Number of cells
Open during inspection period		
Antrim	Antrim and Newtownabbey	20
Armagh*	Armagh, Banbridge and Craigavon	4
Coleraine	Causeway and the Glens	10
Dungannon	Mid-Ulster	5
Enniskillen	Fermanagh and Omagh	8
Lurgan	Armagh, Banbridge and Craigavon	6
Musgrave	Belfast City	50
Omagh	Fermanagh and Omagh	10
Strabane	Derry City and Strabane	6
Strand Road	Derry City and Strabane	9
	Total	**128**
Closed for refurbishment during inspection period		
Banbridge	Armagh, Banbridge and Craigavon	7
Bangor	North Down and Ards	7

**Temporarily opened whilst Banbridge closed for refurbishment.*

1.15 The PSNI PACE Order Statistics[8] show that there has been a small but consistent reduction in the number of persons detained in PACE designated custody suites over recent years from 25,258 in 2012-13, to 24,648 in 2013-14 to 24,377 in 2014-15. This is in line with the downward trend in recorded crime over this period. The custody element of the PSNI's Niche RMS required Custody Officers to collect information from detainees when booking them into the custody suite. This provided the PSNI with a data source of background details of detainees. Table 2 highlights equality and population data collected by the PSNI, which illustrates the characteristics of detainees (where figures do not total 100% this is because of percentages being rounded up).

8 The bulletin contains figures relating to the number of persons detained under PACE. Excluded are those arrested under legislation other than PACE, for example the Terrorism Act. Accessed online at the PSNI website: http://www.psni.police.uk/index/updates/updates_statistics/police_and_criminal_evidence.htm.

1.16 The Equality Commission's guidance on collecting information about religious denomination as part of monitoring Section 75 data[9] suggests using the questions asked in the 2001 Northern Ireland census of population. This suggests, depending on the desired outcome, that as a minimum the PSNI should ask individuals which of the four main denominations they belong to i.e. Roman Catholic, Presbyterian Church in Ireland, Church of Ireland or Methodist with a write-in category for those belonging to another religious denomination as well as the category of none. An expanded version includes the four main denominations listed above as well as the categories of Other Christian and then other religions and philosophies (i.e. Buddhist, Hindu, Jewish etc.).

1.17 In collecting responses of detainees about their religious denomination Custody Officers select from a pre-defined drop-down menu of categories on Niche RMS. The category of Protestant is used to cover all Christian denominations apart from Roman Catholic. It appears in using this question and the available responses, that the PSNI have merged two monitoring areas of religion and community background (i.e. whether the individual considers themselves to be a member of the Roman Catholic community or the Protestant community). Because of this, CJI do not have confidence that of the 17% who declare themselves to be of no religious denomination, would not declare themselves to be a member of the Roman Catholic community or the Protestant community if the question were worded differently to ask about community background. A desirable outcome for the PSNI would be to assess if there is any adverse impact on either community in arrest and detention practice. Using the current monitoring procedures means that the PSNI are unable to use the data in this way to any degree of confidence. This issue will be reviewed further in a forthcoming inspection by CJI looking at equality and diversity monitoring by the criminal justice system.

1.18 The collection of information at the custody desk also afforded the PSNI an opportunity to consider the detainees' individual needs and vulnerabilities for risk assessment purposes. The data collected offers an insight into the challenging nature of the detainee population as illustrated in the Table 2.

9 Section 75 of the Northern Ireland Act 1998: Monitoring guidance for use by public authorities, Equality Commission for Northern Ireland 2007.

Table 2: Equality and population data

Alcohol
In April 2015 30% of all detainees were deemed as drunk.

Disability
In 2014-15 there were **4,832** incidences of **disability** declared by detainees (some detainees declared themselves to have more than one type of disability). Of those **49%** (2,376) related to a **mental health** issue, **21%** (1,032) related to a **physical** disability, **15%** (702) related to a **long-term illness,** 13% (651) to a **learning** disability and 1% (71) to a **sensory** disability.

Dependents
In 2014-15 three quarters of those detained did not declare any caring responsibilities. However **19%** (5,445) declared that they had caring responsibility for a child.

Hospital visits
There were 2,221 detained persons through custody during the month of April 2015. Out of these **86** detained persons required **one** visit to hospital which equated to **4%.** There were also **six** detained persons who required **two** visits to hospital during their time in custody.

Level of observation
Custody Officers make decisions about the level of observation the detainee should be placed under during their time in custody based on the risk factors they present (for example, if they are deemed drunk, to have taken drugs, are believed to be likely to attempt self-harm etc.).

The analysis of the Niche RMS data for April 2015 show that **50%** of detained persons in custody required Level 1 **general observation** (checked at least every hour), **29%** required Level 2 **intermittent observation** (visited and roused at least every 30 minutes), **8%** required Level 3 **constant observation** (constantly observed using closed-circuit television (CCTV) in addition to physical checks at least every 30 minutes) and **4%** required Level 4 **close proximity** (detainee physically supervised in close proximity).

Strategic and service-wide issues

2.1 The area of the Expectations framework relating to strategic and service-wide issues includes expectations relating to:

- a policy focus at Chief Officer level concerned with:
  - developing and maintaining the custody estate;
  - staffing suites with trained staff;
  - managing risks;
  - meeting health, wellbeing and diverse needs of detainees; and
  - working effectively with partners.

- management structures to ensure:
  - appropriate policies and procedures are in place and fully implemented;
  - custody delivery is proactively managed against agreed standards and performance measures;
  - use of force, adverse incidents and complaints are proactively monitored locally and at service-wide level; and
  - there are partnership arrangements and constructive engagement, including at Criminal Justice Board level.

Governance and management structures

2.2 The 2015-16 NIPB Policing Plan listed custody reform as a ServiceFirst Continuous Improvement project. This was described as being *'to optimise custody estate and healthcare provision to ensure that it is fit for purpose and sustainable'.* The Policing Plan highlighted that the custody estate closures would continue to April 2016. The Policing Board's 2012 Human Rights Annual Report[10] included a recommendation that *'the PSNI should provide to the Human Rights and Professional Standards Committee, within six months of the publication of the Human Rights Annual Report 2012, a report on its review of healthcare provision in police custody suites. That report should include any specific consideration given to ensuring that all healthcare professionals are sufficiently experienced and independent from the police, particularly in respect of terrorism detainees'.*

10 Human Rights Annual Report 2012: Monitoring the compliance of the Police Service of Northern Ireland with the Human Rights Act 1998, Northern Ireland Policing Board, 2012.

2.3 The Assistant Chief Constable for the Service Improvement Department was the portfolio holder for custody issues within the Reducing Reoffending and Custody Branch. A team had been established to drive forward the custody change programme, entitled Custody 2020 Reform. This team had responsibility for managing the change programme, contract management of the FMOs, working with internal and external partners and undertaking analysis of management information to support decision making. The team was accountable to the Chief Superintendent of the Service Improvement Department. A Chief Superintendent from District Policing Command had also been appointed to support the team from a Gold Commander perspective with a Superintendent from Belfast City District Command Unit, based in Musgrave Police Station, appointed as Silver Commander.

2.4 Strategic partnerships were utilised in the area of custody with the NICTS, the Northern Ireland Prison Service (NIPS) and the DoJ and DHSSPS. The PSNI were engaged in strategic discussions with partners about healthcare in custody, escorting, court rationalisation and reducing offending. A Memorandum of Understanding was in place between the PSNI and Home Office Immigration Enforcement in respect of immigration detainees brought to custody suites. Representatives of Reducing Offending and Safer Custody Branch had appeared before the Committee for Justice at the Northern Ireland Assembly to give evidence about legislation affecting custody.

2.5 The Head of the Reducing Reoffending and Custody Branch also chaired the Custody Operational Group which was a forum for sharing information and raising issues within custody. The Group included representatives from the Custody Inspectors, Training Branch, the Police Federation for Northern Ireland, Health and Safety, Estates, Information and Communication Services, the Mindwise Appropriate Adult Scheme, the FMOs, the NIPB Independent Custody Visiting Scheme and Resource/Noonan (the contractor who provided CDOs).

2.6 Operationally there had been changes to the management structures of the custody suites since the changes to police districts from 1 April 2015.[11] The day-to-day delivery of custody fell under the command of the Assistant Chief Constable for District Policing Command. Custody was to be managed at an area level (i.e. Belfast City, North or South) by an Area Superintendant with day-to-day responsibility falling to a local Custody Inspector. At the time of the fieldwork, custody was managed at an operational level by a designated Inspector in each district as part of their duties as a response Inspector. Antrim Custody Suite had a dedicated Custody Inspector as did Musgrave Custody Suite, although in the latter the Inspector had other duties outside of custody. The move to management at an area level would enable custody to be managed as an area-wide resource, including the ability to deploy staff across different suites.

2.7 In the 2009 CJI report it was recommended that: *'The PSNI puts in place organisational arrangements for the support of Custody Sergeants to ensure greater consistency in role and practice across the service'.* This recommendation was deemed to be not achieved in the follow-up review of 2013. The recent management and structural changes therefore theoretically should provide this greater level of consistency, given that there would be a greater ability to use both the physical estate as well as the staff

11 On 1 April 2015 the PSNI moved from eight to 11 policing districts. The new districts were aligned to the new local councils in Northern Ireland as a result of the Review of Public Administration.

in a more flexible way. At the time of inspection fieldwork it was too early to tell whether this had been achieved but initial observations, even prior to the introduction of the new areas, were promising, for example in a greater application of the principle of the detainee being taken to the nearest station to the point of arrest.

2.8 There were a range of custody policies in place which provided guidance for custody staff as to how to manage the various aspects of custody. These mainly existed from 2008 but were due to be reviewed in 2015.

Custody 2020 Reform Programme

2.9 The PSNI were engaged in a programme to modernise and rationalise the custody estate. This involved the closure of custody suites which were either too small, inappropriately located for arrests within the policing district or unfit for purpose and difficult to modernise. At the time of the 2009 inspection the PSNI had 21 custody suites containing 144 cells. At the time of fieldwork for this inspection, this number had reduced to 11 containing 138 cells (with an additional three celled suites available to be opened when other suites were undergoing refurbishment), with plans to reduce to nine suites containing 132 cells by 2020. To support this, a rolling refurbishment programme was ongoing (which necessitated some suites being reopened to ensure capacity was maintained) over 2015-16. In the longer term there were plans at design stage to build a new purpose-built 21 celled custody suite in the Waterside of Derry/Londonderry, which would eventually enable Strand Road custody suite to be closed. Scoping was also underway for a further new build in the Craigavon area but this would depend on capital being available in future years.

2.10 To support this change programme analysis of management data obtained from the Niche RMS had been used to aid decision making. The Reducing Reoffending and Custody Branch had presented various pieces of information to the Executive Team, for example showing the number of arrests and detained persons (and the reductions in these over the past few years), the location of the arrests made, the custody suite detainees were taken to, and the length of time detainees were held for. This had enabled decisions to be made about required capacity, the most appropriate locations of custody suites and future staffing levels, based on sound evidence rather than anecdote. This information was particularly welcomed by Estates Branch when developing plans for the custody estate. Inspectors welcome any such use of data to inform decision making and ensure a custody estate that meets the needs of the service.

Staffing the custody suites

2.11 In 2009 CJI recommended that *'Officers should be dedicated to the role of Custody Sergeant, and have priority access to places on the custody course and refresher training, as well as handover briefing time built into their working patterns'.* It was apparent during this inspection that there was better use of dedicated Custody Officers or, in the event of sickness or other short notice absences, the use of regular 'stand-in' Custody Officers. None of the Custody Officers spoken to felt that they had been asked to stand in without sufficient recent training or experience to make them feel confident to perform the role.

2.12 CDOs were provided by a contractor, Resource/Noonan, and all had received training when they commenced the role. There were some issues raised with regards to provision of uniform and terms and conditions of the role but all felt professionally managed by PSNI Custody Officers and their own supervisors on a day-to-day basis. Whilst the appointment of the CDOs had been a recent initiative at the time of the 2009 inspection, they were a well established team within the custody suites, and Custody Officers were complimentary about the role they performed, with some having gained a number of years of experience and developed excellent skills in dealing with difficult detainees.

2.13 Courses for new Custody Officers had not been delivered since 2013 but were planned once the recent promotion process had been completed. Training Branch was represented on the Custody Operational Group and found this useful as a way of gaining perspectives on potential training issues arising in custody. A coaching and mentoring programme had been developed with workshops held for Custody Officers in order that they could then help develop colleagues with less experience. Due to natural wastage the CDO contractor was recruiting additional staff at the time of inspection with the intention that they would receive training by the PSNI in autumn 2015.

2.14 Refresher training for custody staff had tended to be focused upon mandatory personal safety training, first aid and use of the defibrillator and oxygen. Custody Officers had received updated training on new developments in the Niche RMS, for example an ability to search the police national computer and a new whiteboard feature. There was no specific refresher training course in the area of custody generally, although Training Branch was developing a continuous professional development course for full-time and back-fill Custody Officers which would cover Article 2 of the Human Rights Act (the 'Right to Life') issues arising from deaths in custody, health and safety, the care plan aspect of Niche RMS in custody and an input from a FMO about issues arising in custody. ***Future training for Custody Officers should include an input on child protection, vulnerable adults and mental health issues.***

2.15 Both permanent and back-fill Custody Officers confirmed that they could access policies and guidance in relation to custody issues on the custody area of the PoliceNet intranet site. They also received updates via email from the Custody Policy Inspector, for example regarding near misses or risk assessment issues.

2.16 Custody suites were staffed on a static rather than flexible or demand-led staffing model. Each suite therefore had allocated staffing numbers, based on the number of cells, for example one Custody Officer and one CDO for six cells in Strabane, but greater numbers in larger suites such as Musgrave or Strand Road. This meant that there was the same staffing levels mid-week, when numbers of arrests were low, as on potentially busy Friday and Saturday nights.

2.17 The issue was exacerbated if detainees were brought to the custody suite who were particularly resource intensive for the custody staff, for example detainees who were intoxicated or on drugs and required close or frequent observation, those who were violent or particularly vulnerable and needed additional support. Suites without in-cell sanitation were also more resource intensive due to the need to unlock detainees and escort them to the toilet.

2.18 Custody staff gave examples of times where they had been under pressure to conduct all the necessary searches and processing of detainees, take detainees to medical and solicitors consultations, prepare meals and update the Niche RMS when dealing with a full custody suite or a suite with several challenging detainees. On occasions Custody Sergeants advised that they had felt they needed to close the suite even if cells were free because of the detainee population. This was in contrast to periods of downtime in the middle of the day mid-week where the suite may have only one or two, or even no detainees in situ.

2.19 In the event of a known event which may result in a surge in arrests and therefore need for additional capacity the PSNI could request additional staff from the managed service contractor Resource/Noonan. However as this requirement was not included in the contract there was no obligation on them to provide this and it was done on a good will basis. The PSNI had started to analyse data available through the Niche RMS which showed the throughput of each custody suite, where the arrests were coming from and the times and days that detainees were being held in the custody suite. This would potentially enable them to move to a more flexible demand-led staffing model once new management structures for custody within the PSNI had been fully realised and when a new contract for CDOs was established, with greater numbers of staff at peak times. The initial managed service contract period with Resource/Noonan had come to an end but under the terms of the contract, could be extended.

Strategic recommendation 1

Inspectors recommend that the PSNI move to a more flexible, demand-led staffing model for both Custody Officers and CDOs, and that this is reflected in any future agreement for a managed service contract for CDOs.

Meeting the needs of detainees

2.20 The Reducing Offending and Safer Custody Branch had overall responsibility for the delivery of custody healthcare. Work in this area had been subject to review by the PSNI. An Administrative FMO was responsible for developing rotas and co-ordinating the work of FMOs in each district area but as previously, there was no single lead for the service, albeit the Association of Forensic Medical Officers in Northern Ireland (AFMONI) offered a membership framework for practitioners. The area of healthcare is explored further in Chapter 5.

2.21 In 2011 the Prison Review Team[12] recommended *'there should be a joint healthcare and criminal justice strategy, covering all health and social care trusts, with a joint board overseeing commissioning processes within and outside prisons, to ensure that services exist to support diversion from custody and continuity of care'.* This recommendation had been discussed on an ongoing basis since the report was published by the Prison Review Team oversight group. The PSNI had entered the ongoing discussions being held between the DoJ and DHSSPS to enable them to incorporate delivery of healthcare in police custody into

12 Review of the Northern Ireland Prison Service: conditions, management and oversight of all prisons, Prison Review Team, 2011.

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the Joint Health and Justice Strategy. Progress had been slow however and, at the time of inspection, it had been confirmed to the Prison Review Oversight Group that the final strategy would not be ready for publication until autumn 2016.

2.22 Inspectors were advised that the delivery of the Joint Health and Justice Strategy is critical to the PSNI's ambition to deliver an alternative healthcare model for police custody suites. The PSNI believe that its vision of a healthcare model that includes a multi-disciplinary approach to health with appropriate diversion out of custody, particularly for children and people with mental health issues and addictions, into the wider healthcare setting cannot be realised without such a strategy being in place. There is a clear need to develop supporting delivery mechanisms in parallel with the strategy, for example Memorandum of Understanding and Information Sharing Protocols between the PSNI and health colleagues, in order to ensure that delivery of services can commence soon after the strategy is agreed. CJI and the RQIA will continue to closely monitor the delivery of this strategy by the DoJ and DHSSPS as part of the future inspection process.

Performance management

2.23 As outlined earlier the Niche RMS afforded the PSNI a large source of data regarding the custody population and utilisation of custody suites. For example, this provided data about peak times in custody, the location of arrests and which suite they were transferred to and time spent in custody by detainees. The Custody and Reducing Reoffending Branch had begun to use this data to inform decision making about the Custody Estate Strategy and human resources planning. A decision was to be made as to whether custody data would feature on the PRiDE reporting system[13] available to PSNI managers. Inspectors with responsibility for custody were expected to complete audits of six custody cases every week.

2.24 An Independent Custody Visiting Scheme was in place and managed by the NIPB. The Board's last recruitment process for Custody Visitors had encouraged applications from a more diverse range of volunteers and they had successfully recruited a greater number of female and younger visitors. The Visitors were organised in teams covering three geographical areas (a recent reduction from four to reflect the changes to the PSNI Area Command structure) which enabled good coverage of the suites; Custody Visitors conducted 726 visits in 2014-15 against a guideline number set by the Board of 706. Of the 705 visits that were considered 'valid' (i.e. that the Custody Visitors were able to access the suite and complete the visit) 640 (91%) were found to be entirely satisfactory by the Custody Visitors.[14] Custody staff were positive about the role of the Custody Visitors and Inspectors were provided with examples where they had effected positive change in the custody suites. The Scheme Manager from the Policing Board was represented on the Custody Operational Group and also provided a monthly update to the Reducing Offending and Safer Custody Branch.

13 PRiDE - Performance and Risk in Delivering Excellence is an IBM Business Analytics solution designed to identify patterns of incidents to forecast crime 'hot spots' and proactively allocate resources accordingly.

14 Northern Ireland Independent Custody Visiting Scheme Annual Report 2014-15, NIPB 2015.

2.25 The OPONI was responsible for investigating complaints against police (including complaints against custody staff) as well as deaths in custody. Complaints tended to be related to use of excessive force or neglect of duty, in common with complaints about police generally. In 2014-15 there were 128 failure in duty allegations in the category of 'conduct in custody suite', a reduction from 178 the previous year.[15] However the presence of CCTV in the custody suites made issues much less likely to occur or, where they were reported, to be easier verified. There had been a death in PSNI custody in 2014 which was being investigated during the period of this inspection, and this will be reported on by the OPONI in due course. During such investigations the Ombudsman was able to make early policy recommendations to the PSNI in order that issues could be addressed at the earliest possible opportunity.

2.26 The PSNI Discipline Branch also had a role in dealing with complaints, where the Police Ombudsman had directed the case be dealt with internally. It was estimated that only 10-20 of the 250 files received a year related to custody and the majority of these resulted in advice and guidance being offered to the Officer. The Branch shared data on patterns and trends with District Discipline Champions on a monthly basis as well as circulating the 'Learning the Lessons' Bulletins developed by the Independent Police Complaints Commission (which sometimes contain lessons learned from custody).

2.27 Use of force was recorded in individual custody records on the Niche RMS. There was central monitoring of use of force in relation to use of attenuating energy projectiles, batons, CS spray, firearms, Taser, police dogs and water cannon across the Service as a whole. There was no specific monitoring of use of these types of force, or lower level force (for example, use of leg restraints or handcuffs) in custody suites (see paragraph 3.32).

2.28 Adverse incidents were entered into a reporting system for onward transmission to Health and Safety Branch. These were then trawled to identify significant near misses (for example, where there was a need to call the emergency services) in order to take appropriate action. Safety alert notices were circulated throughout the PSNI including to Custody Officers. Information on adverse incidents was received from the Home Office to identify potential issues arising in England and Wales.

15 Annual Statistical Bulletin of the Police Ombudsman for Northern Ireland 2014-15, OPONI, 2015.

Treatment and conditions

3.1 The area of the framework that considers treatment and conditions for detainees includes expectations relating to:

- treating detainees with respect and ensuring their diverse needs, whilst in custody, are met;
- risk assessment, monitoring and management;
- pre-release risk management planning;
- use of force;
- the custody suite being clean, safe and in a good state of repair;
- ensuring detainees are able to be clean and comfortable while in custody;
- provision of food and drink; and
- the opportunity for exercise, reading materials and visits.

Respect and meeting the diverse needs of detainees

3.2 The background data in the introduction to this report illustrates the diversity of detainees held in PSNI custody suites. Custody staff described how they dealt with the different needs of detainees in their interactions with them, for example in detaining individuals who were wheelchair users, the use of services such as the interpreting and appropriate adult services, experiences of having mothers and babies in the custody suite, searching a transgender detainee and using female Police Officers to deal with female detainees where possible.

3.3 In the 2009 inspection CJI recommended that *'hygiene packs for female detainees which include hygienic and discreet supplies of sanitary items should be obtained and available in the custody suites.'* This recommendation was achieved by the time of the follow-up review and these were still in use in 2015. However it was still the case that female detainees had to request these. On closer questioning custody staff said that detainees would *'know'* that they could ask for a female CDO or Police Officer to access these. Inspectors do not believe this is the case and feel that this could be an awkward situation for a female detainee, particularly for those who are young or are in custody for the first time. Custody Visitors confirmed that female detainees would have to ask a CDO (usually male) for a hygiene pack and they would get a female CDO or Police Officer to provide it. ***Female detainees should be asked a matter of course if they require a hygiene pack by the female CDO or Officer who searches them at the start of the period of detention, in order to save potential embarrassment.***

3.4 Staff had not received child protection training and there were limited facilities for separating children, particularly girls, from the cells where the rest of the detainees were held. In one early morning visit to a busy custody suite Inspectors heard young male detainees shouting to each other through the cell doors of the custody block which created a fairly disruptive environment. A young woman was also held in this block and, whilst she did not remark on the atmosphere, Inspectors felt it could have been quite intimidating for her. Where safe staffing levels allow, it would be more appropriate to hold women, girls and vulnerable detainees away from young and adult males.

Children and young people

3.5 In March 2015 HMIC published a thematic inspection in England and Wales on the welfare of vulnerable people in police custody.[16] The main concerns identified by the inspection were the lack of data and the absence of any real mechanisms of oversight. The inspection made a number of recommendations. Some of these pertain directly to children, including recommendation 17 which reads as follows: *'The business of the National Preventive Mechanism Children and Young People's Sub Group should include a focus on children in police custody, particularly on how effective local diversion arrangements and related public service safeguarding responsibilities are in respect of children.'*

3.6 A further report by HMIC published in July 2015[17] also commented on the use of police custody for children in England and Wales as follows: *'HMIC has concerns about the detention of children in police custody. While it may be necessary to arrest a child or a child may need to be detained for their own safety, these occasions should be relatively rare. In particular, Inspectors were concerned by the number of 'looked after' children held in police custody. Local authorities are required by law to accommodate children who would otherwise be detained in custody overnight, and it is a serious matter that children who are already in their care are denied this accommodation.'* In Northern Ireland responsibility for the care of 'looked after' children falls to Social Services rather than local authorities. Within PACE however there is no equivalent role for Social Services in accommodating children who would otherwise be in police custody.

3.7 The holding of children in police custody was a specific focus of the Expectations for this inspection and therefore information was sought from the PSNI about their treatment of children and young people. As highlighted in the introductory chapter, 10% of individuals detained in police custody in 2014-15 were children and young people aged 17 years or less, equating to 2,438 detainees. Custody staff described their efforts to reduce the impact of custody on children and young people in their care, for example by placing them in a cell or holding area near the custody desk, ensuring they were able to keep themselves occupied (for example, providing reading material, offering additional telephone calls etc.) and in spending more time talking to them.

3.8 A report on bail by the Northern Ireland Law Commission published in 2012[18] extensively discussed the right to bail and grounds for refusal for children and young people. In the Law Commission's consultation paper, inconsistencies between the tests for bail in respect of children and young people applied by the police and the courts were highlighted. The report noted: *'There is a strong presumption in favour of bail*

16 The welfare of vulnerable people in custody, HMIC 2015.
17 In harm's way: the role of the police in keeping children safe, HMIC 2015.
18 Bail in criminal proceedings, Northern Ireland Law Commission 14, 2012.

for young persons, with remand only available for certain offences or in certain circumstances and with an over-riding emphasis on the protection of the public. By contrast, the police enjoy broad powers to detain young persons following charge for all the same reasons as adults, with the additional power to detain a young person in their own interests. It was argued in the consultation paper that the inconsistency between the powers of the police and the courts to detain children and young persons accused of offences, coupled with the lack of availability of suitable bail accommodation for many young persons, may contribute in part to the large number of short term PACE admissions to the Juvenile Justice Centre.' The findings of this inspection also suggests that this issue has an impact on the numbers of young people held in police cells after charge.

3.9 The Law Commission report therefore made the following recommendations in respect of bail for children and young people:

'Recommendation 36

The Commission recommends that the general right to bail for all persons accused of offences or awaiting trial, subject to the power of the police or the courts to refuse bail, should also apply to children and young persons accused of offences. Therefore such children and young persons should have a right to bail unless there are substantial grounds for believing that if granted bail the child or young person would:

- *fail to surrender to custody;*
- *interfere with witnesses or otherwise obstruct the course of justice; and*
- *commit offences.*

Bail may also be refused if there are substantial grounds for believing that the detention of the child or young person is necessary to preserve public order.

Recommendation 37

The Commission recommends that, in addition to the list of factors which, if relevant, must be considered when decision makers are determining if detention is justified in respect of adults accused of offences, decision makers must also consider the following factors when determining if detention is justified in respect of a child or young person accused of an offence:

- *the age, maturity, needs and understanding of the young person;*
- *the best interests of the child as a primary consideration; and*
- *that detention pending trial must be used only as a measure of last resort and for the shortest possible period of time.*

Recommendation 38

The Commission recommends that bail legislation should prohibit the detention of children and young persons solely on the grounds of a lack of suitable accommodation.'

3.10 Previously the report of the Youth Justice Review of Northern Ireland and the monitoring reports on this by CJI,[19] as well as the Northern Ireland Law Commission's report, have commented on the use of Woodlands Juvenile Justice Centre in Bangor for overnight PACE admissions. The Youth Justice Agency recently reported[20] that in 2014-15 there were 645 transactions in the Juvenile Justice Centre, of which 233 (36%) related to PACE. Whilst the report noted that between 2013-14 and 2014-15 the actual number of PACE transactions decreased by 29%, it suggested that this was in part due to the refusal of PACE admissions to Woodlands between August and October 2014.

3.11 The 2015 CJI report on Woodlands stated: *'The rate and origins of PACE admissions were concerning when we inspected in 2011, and that remained the case in 2014. Proximity was never intended to be a criterion or justification for committing children to custody... 50% of all PACE admissions came from Greater Belfast and Bangor police stations. The Belfast rate is unsurprising, since it is the largest centre of population in Northern Ireland. However the high rate from Bangor police station suggests proximity was a factor in the JJC being used for PACE admissions; and police from further afield were less likely to take children there for short periods of detention.'* The Northern Ireland Non-Government Organisation Alternative Report[21] cited figures obtained from the DoJ that in 2014, there were 245 PACE admissions to the Juvenile Justice Centre of which 95 were relating to children from care homes. Of these 245 admissions, 110 were released at court the following day. The use of the Juvenile Justice Centre is not considered a suitable alternative to police custody, given the long travel distances to Woodlands from much of Northern Ireland having negative effects on the detainee being transported as well as disruption to the young people held in the Juvenile Justice Centre already.

3.12 Guidance provided to Social Services residential and field staff also reiterates the statement in PACE (Northern Ireland) that children are not to be held in police custody other than in 'exceptional cases'.[22] A Judicial Review by MP (a minor) against a decision of the Belfast Health and Social Care Trust in 2014[23] goes further. The Judge in that case concluded that there was a legal duty on the Trust to provide accommodation to the young person, MP, who had been charged and remanded into custody at the Juvenile Justice Centre, and the Trust had failed to fulfil this duty. Accordingly, the duty on Trusts to provide accommodation for young people may apply to other detained children, for example in police custody, when bail and remand decisions are being made. Although this had not yet been tested in court, it demonstrates the complexity of decisions that have to be taken by the PSNI regarding young people in custody.

3.13 During the fieldwork police custody staff did not appear to appreciate that children who were charged could, or indeed should, be held anywhere except a police cell or Woodlands Juvenile Justice Centre. However a review of custody records for juveniles showed that Custody Officers, in many cases, did make

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19 The review of the youth justice system in Northern Ireland, Youth Justice Review Team 2011; Monitoring of progress on implementation of the Youth Justice Review recommendations, CJI 2013 and December 2015.

20 Youth Justice Agency Annual Workload Statistics 2014-15, Statistical Bulletin 1/2015, N O'Neill, 2015.

21 Northern Ireland Non-Government Organisation Alternative Report: Submission to the United Nations Committee on the Rights of the Child for consideration during the Committee's examination of the United Kingdom of Great Britain and Northern Ireland Government report (May 2014), Children's Law Centre and Save the Children Northern Ireland, June 2015.

22 Regional guidance for residential care and field social work staff on supporting looked after children who are arrested/questioned by police or appear in court on criminal matters, DHSSPS 2011.

23 MP's (a minor) Application [2014] NIQB 52.

efforts to engage social workers in seeking alternative accommodation for children as well as utilising Woodlands where it was possible. In none of the records reviewed however did Social Services provide a placement for a child denied bail, with one social worker recorded as commenting that there was no place for the child in the 'whole of Northern Ireland'.

3.14 The PSNI were asked to provide data outlining the disposals used for children and young people in comparison to adults. CJI reviewed these figures and some custody records to seek further details as to how many juveniles were denied bail and kept in custody and/or transferred to the Juvenile Justice Centre. However due to the way the information is input into the Niche RMS the data did not give an accurate picture of the ultimate disposal for each individual following their detention in custody. It would therefore be difficult for the PSNI to use this data for decision-making. This is an issue that will be reviewed further in CJI's forthcoming inspection on the use of management information by the criminal justice system in Northern Ireland. Despite this, what the review of the data, plus information and data collected for other CJI reports strongly suggests is that, because of the lack of alternative accommodation provided by statutory agencies for children and their inability to seek their own accommodation in the way that adults do, children and young people are more likely to be held in police cells than adults are once bail is denied.

3.15 The CJI reports on the monitoring of the Youth Justice Review found that a Bail Information Scheme had been set up by the Youth Justice Agency through which bail information was presented to the court at the young person's first appearance. The 2015 CJI report on the Youth Justice Review stated that *'The YJA* [Youth Justice Agency] *had identified the need to link with Health and Social Care Trusts regarding the issue of accommodation provision which was seen to be a challenge. There was an ongoing issue regarding a lack of suitable accommodation for 16-17 year olds who weren't 'looked after' children under the care of social services and therefore social services would not assume responsibility for them.'* The same issues regarding the absence of alternative accommodation apply in respect of children and young people who have been charged and are being held in police custody prior to attending court. In addition, a lack of alternative accommodation for children who had not been charged with an offence but were for some reason unable to return to the family home, was raised as an issue by custody staff.

3.16 In July 2013, following the 2012 Northern Ireland Law Commission bail report, the Justice Minister announced a consultation on proposed changes to bail legislation and it was intended that a Bail Act would be brought before the Assembly in 2015. It was decided that further discussions were required on the issues around bail for children and young people prior to legislation being progressed. To date, and at the time of writing however, due to other legislative priorities, a Bail Act for Northern Ireland has not been brought before the Committee for Justice.

3.17 Inspectors believe that a Bail Act is necessary to resolve the difficulties with the existing legislation to reduce the numbers of children and young people held in police custody after charge. Any change to legislation which places a duty on Social Services to provide alternative accommodation in Northern Ireland, as is the case with local authorities in England and Wales, would obviously require a partnership approach between the DoJ and DHSSPS. A scoping study of children in the criminal justice system was announced in May 2015 and Inspectors understand that the issue of bail and places of safety for children were to be included in this piece of work.

3.18 Inspectors recommend that legislative reform is required in the following areas.

Strategic recommendation 2

It is recommended that the DoJ should:

- **firstly; bring forward a Bail Act to implement the recommendations of the Law Commission in respect of the right to bail for children and young people to the Assembly at the first available opportunity in the new Assembly mandate; and**
- **secondly; bring forward changes to PACE which make provisions for alternative accommodation for children who are charged with an offence which clarify the legislative position about the detention of children and young people for Custody Officers.**

Safety

3.19 Custody Officers and CDOs were alive to the risks in the custody environment and found these challenging to deal with. They cited examples of situations where they had dealt with detainees who were under the influence of excessive amounts of alcohol and/or drugs, suffering mental health issues, were violent to staff or property or demonstrated suicidal or self-harming tendencies. Figures provided in the introduction to this report offer an insight into how commonplace risks were although in reality the potential risks are likely to be higher given the fact that some detainees may not display outwards signs of such issues to the custody staff.

3.20 Handover time was built into the shift pattern of Custody Officers in order to discuss each detainee in the suite and highlight areas of risk. CDOs also had a team handover although time for this was not specifically built into the shift pattern. A whiteboard was located in each custody office, out of sight of anyone standing at the desk, on which information on each cell occupant was listed including risks and observation levels. The Niche RMS had also recently been updated to include a whiteboard screen, which showed an overview of each detainee and again highlighted risks and alerts via 'warning markers'. Information from the police national computer was also available on the Niche RMS, which therefore assisted in undertaking person checks and identifying individuals with a previous history of violence or drug offences.

3.21 The Niche RMS required the Custody Officer to ask the detainee questions in order to assist in their risk assessment (for example, if they had taken alcohol or drugs, had previous suicidal thoughts etc.). This information was also then complemented by observations by arresting Officers and custody staff, searches of detainees (for example, for drug paraphernalia), concerns raised by the FMO and information available on the Niche RMS about previous occasions where the detainee had been held in custody. The Niche RMS also then contained a care plan element where Custody Officers recorded the required levels of observation for the detainee, any particular concerns or actions and could place a 'flag' or warning marker on the system to highlight risks to custody staff.

3.22 The PSNI followed the levels of observation advised by the College of Policing Authorised Professional Practice on Custody and Detention:

- Level 1 **general observation** (checked at least every hour);
- Level 2 **intermittent observation** (visited and roused at least every 30 minutes);
- Level 3 c**onstant observation** (constantly observed using CCTV in addition to physical checks at least every 30 minutes); and
- Level 4 **close proximity** (detainee physically supervised in close proximity).

All but one of the suites visited had CCTV installed in the custody suite and cells in order to assist in the observation process. Custody staff were required to record on the Niche RMS that they had conducted observations at the appropriate level. The issue of whether to rouse the detainee was a challenge for Custody Officers in striking the balance between ensuring the detainee was alive and well, but affording them a chance to have un-interrupted sleep and not aggravating a potentially violent individual.

3.23 Custody staff cited mental health issues and the consumption of drugs by detainees as the most challenging aspect of their work. CDOs particularly highlighted that, in their view, the level of drug abuse by detainees had increased dramatically since the previous inspection and that there had been a resulting increase in violence against custody staff and therefore injuries suffered. They had also seen an increase in self-harm and the use of so-called 'legal highs' by detainees. They advised however that they learned about drugs from the detainees themselves. It is difficult however for any training programme to keep pace with the development of new illegal drugs and 'legal highs'. One example of this was noted in the review of custody records as outlined in the box below.

A young man, aged between 17 and 21 years old, was arrested in the early hours of the morning whilst under the influence of alcohol and drugs. As a result of being intoxicated he was violent, which meant that the Custody Officer was unable to conduct a risk assessment on his arrival at the custody suite. He had however, been flagged as having suicidal tendencies on a previous occasion in custody. He was therefore taken immediately to a cell at 0310 hours and placed under constant observation. The FMO was recorded as arriving and reviewing him in his cell at 0328. Following this he was placed under 15 minute observations with rousing and then later this was reduced to 30 minute observations. The detainee felt he had been treated 'very badly' by the police (in response to the survey question) and, as a result, had made a complaint to the Police Ombudsman. This was clearly a difficult situation for all involved.

3.24 Custody Officers and CDOs received an input on their training courses from Health and Safety Branch on risk assessment. Detainees were placed under constant supervision by custody staff when out of their cells. Potential ligature points within these areas were minimised and regularly checked. Within the cells, observations were risk-based in an environment designed to Home Office Standards, which was in good condition and with a risk adverse fabric/design policy and works programme to resolutely minimise detainee or staff harm. Staff all carried cell keys or fobs and had personal issue ligature knives, although CDOs highlighted that there were insufficient numbers of belts on which to hang them. Cells in most custody suites contained CCTV which was viewable in the custody office and some suites had 'lifesigns

monitoring' that, in limited circumstances, could be used to assist monitoring of vulnerable detainees. Since the last inspection and the investigation into a death of a detainee in Strand Road custody suite in 2009[24] all solicitor's consultation rooms had been fitted with an external lock so that the solicitor had to press a call bell to request that they (and the detainee) be released from the room.

3.25 Since the last inspection there had been a policy decision that drawstrings in clothing such as a hooded tops or tracksuit bottoms, had to be removed before detainees were placed in cells. In reality, because detainees were understandably reluctant to remove these from their clothing, this meant that a greater number of detainees were provided with alternative clothing from PSNI stock. In our survey 58% of detainees stated they were given a tracksuit to wear compared to 10% in 2009. Whilst this clearly reduces the risks of a detainee attempting suicide it inevitably has cost implications for the PSNI as the clothing was single issue and therefore was destroyed once the detainee was released. The PSNI may wish, in future, to review the impact of such a blanket approach compared to the previous risk-based approach.

3.26 Musgrave Street, Strand Road and Antrim custody suites had more than one booking in desk which could be used when required to process more than one detainee at a time. In other stations when the suite was busy detainees were either held in the police car in the vehicle dock or station yard, or occasionally for example with children, kept in a holding cell whilst waiting to be processed. Officers raised concerns that at peak times arresting Officers could be held in the vehicle dock for up to two or three hours waiting for their detainee to be processed. The additional travel time for arresting Officers was also raised as a concern, particularly with the reduction in suites or temporary closures. Data on the detainee journey was beginning to be analysed and monitored by Reducing Reoffending and Custody Branch. The need to cater for such fluctuations in demand reinforces the need for a more flexible approach to staffing, as highlighted in Chapter 2.

3.27 Violent detainees could be taken straight to a cell by arresting Officers if they were considered a danger to custody staff and then talked down by custody staff prior to completing the booking in procedure. Often arresting Officers had to stay with violent detainees because staffing levels of CDOs did not offer sufficient numbers for the required level of observation. In addition, on occasions where a detainee needed to be taken to hospital, Response Officers were required to escort them. This could place pressures on response sections. Cells were checked during the cell refresh or cleaning process by the CDO or cleaner in between occupants for any unauthorised items.

Pre-release planning

3.28 A Prisoner Escort Form was generated by the Niche RMS for those detainees transferred to court and onwards to prison, which highlighted categories of risk such as drugs, mental health issues, potential for self-harm/suicide and potential for violence. Custody Officers could then enter further detail on this sheet, although in those viewed at Maghaberry Prison information was scant; for example *'DP [detained person] states self-harm issues'.*

24 Mr John Brady hanged himself after being left unsupervised in a solicitor's consultation room in Strand Road custody suite in October 2009.

3.29 Mindwise, who ran the Northern Ireland Appropriate Adult Scheme, also ran a project called Linked-In which works with young people who were due to leave or had just left police custody to offer guidance or support. This was a pilot project working across Belfast, Antrim, Derry/Londonderry. It aimed to reduce re-offending and improve mental health and well-being by helping young people to address factors that impact negatively on their lives.

3.30 There was no evidence of any other formal processes to signpost individuals to other partner agencies after their release from custody. Some custody staff stated that they had leaflets available regarding local alcohol or drug addiction services but these were given to detainees with no way of knowing if they would avail of the service (indeed some were said to rip up the referral sheet given them) and there was no follow up of them.

Use of force

3.31 Both Custody Officers and CDOs received Personal Safety Programme refresher training on an annual basis. CDOs in particular, showed knowledge of the need to attempt to de-escalate conflict situations by talking to detainees and drawing a distinction between their role and that of Police Officers. Staff could not identify specific alternative procedures that would be applied to those with a known health problem, children or pregnant women, although some stated that training had covered restraint of special groups.

3.32 Leg restraints and handcuffs were available in the custody suites for use with violent detainees and were reported to be used fairly frequently. Staff confirmed that these were used for a minimum amount of time, particularly as the detainee often calmed down once the arresting Officers had handed over the detainee to custody staff. Only 15% of detainees in our survey stated that they had been restrained whilst in the custody suite, compared to 40% in 2009, and 90% confirmed their handcuffs were removed on arrival. In the review of custody records there was evidence of detainees being restrained whilst in custody and resulting actions, such as the FMO being called to examine the detainee and enhanced levels of observation. One example is highlighted below.

> A young man, in the age group of 17 to 21 years, assaulted the arresting Officers at the custody desk. He was therefore placed in leg restraints and cuffs and taken to a cell. He was flagged on Niche RMS as being a high-risk detainee with known tendencies for self-harm. The FMO examined him in the cell due to the risks associated with taking him to the medical room. He was placed under constant observation during the two-and-a-half hours he was in the restraints. Once he had calmed down, the restraints were removed and he was reviewed again by the FMO. His level of observation was then reduced to every 15 minutes. Whilst the detainee advised Inspectors that he had been frightened by the incident he did acknowledge that he had been restrained because he had 'kicked off' whilst at the custody desk.

3.33 Occasions where force was used were recorded on the custody record on the Niche RMS and detainees were examined by the FMO after any use of force. Any use of force, such as the use of a baton, CS irritant spray or Taser in any circumstances by Police Officers was collated and reported to the Policing Board on a six-monthly basis, as well as being published on the PSNI website. In addition the Police Ombudsman

reviewed all Taser discharges. Such significant uses of force were reported not to be used in the custody suite. Staff appeared aware of the procedures to take in the event that a detainee arrived at the custody suite having been subject to CS irritant spray or a Taser weapon.

3.34 The College of Policing Detention and Custody Authorised Professional Practice module recommends the following in relation to use of force: [25]

'Forces should collate use of force data electronically (the Home Office is considering mechanisms for annual data returns in this regard). Forces are expected to record all instances of use of force electronically and in such a way that allows for ready retrieval and analysis of this information. In particular, this data should allow for analysis by age, ethnicity and offence and should form part of the custody record or be explicitly referenced in it. In recording the use of force, officers and staff should use the following categories as a minimum:

- *baton/asp;*
- *Taser;*
- *incapacitant spray;*
- *handcuffs;*
- *open hand techniques; and*
- *prone restraint.'*

At the time of inspection this information was recorded on the custody record on Niche RMS and did not appear to be collated or analysed in any way. Whilst the PSNI is not a Home Office force and therefore not obliged to follow this guidance, it would be sensible to adopt this approach to use for management information purposes, for example in human resources planning and risk management. ***The PSNI should follow College of Policing guidance in respect of collating use of force data.*** Custody Inspectors raised no concerns with the use of force in their custody suites.

Physical conditions

3.35 Cells were all fitted with call bells and 62% of detainees in our survey confirmed that staff explained the correct use of these. Inspectors saw evidence of staff responding to call bells promptly. Staff reported that maintenance arrangements for the suite were good and that faults reported were repaired promptly, with different call out times depending on the nature of the fault and how essential it was; either within three hours or two or three days. An annual inspection of the suite was undertaken by the facilities management contractor which then resulted in planned maintenance and refurbishment being conducted on a rolling basis. Inspectors also saw evidence of specific cells being closed due to faults which would result in the cell being potentially unsafe (for example peeling paint which could be used for self-harm).

3.36 Whilst none of the custody suites reported having been involved in a fire or bomb evacuation drill whilst detainees were present, staff showed an understanding of the process to be followed and were made aware by the station staff when drills would take place. Cell or custody suite closures could be initiated by Custody Officers or Custody Inspectors, for example if the cells were unfit to be used or capacity had been

25 Available on-line at https://www.app.college.police.uk/app-content/detention-and-custody-2/control-restraint-and-searches/.

reached based on the numbers and types of detainees, and arresting Officers were diverted to the next available custody suite. This could prove challenging given the distances between suites and the impact on Officers, detainees and their advocates.

Detainee care

3.37 Mattresses, pillows and clean blankets were provided to detainees with blankets either being sent for laundering between uses or for disposal if they had become soiled with blood, bodily fluids or excrement. In most suites there was in-cell sanitation which was occluded on CCTV images. Toilet paper was available in most cells although in some suites the staff continued the practice of providing this on request. Detainees were given a wash kit consisting of soap, a sachet of shampoo and a disposable toothbrush/paste kit. Showers were available but their use was limited; only 30% of detainees held for over 24 hours surveyed confirmed they had been offered a shower (a decrease from 38% in 2009) although staff said that detainees often declined the opportunity. Since the last inspection detainees were no longer given razors for shaving due to the potential for self-harm.

3.38 As highlighted above female detainees were not routinely offered hygiene packs on arrival although these were available on request. Alternative clothing was available in a range of sizes and was disposed of after wearing and relatives or friends could bring in a change of clothes, which were searched prior to giving to the detainee. The inability to smoke continued to be an issue for detainees and of those that smoked only 24% of detainees surveyed stated that they had been offered anything to cope with not being able to smoke (an increase from 20% in 2009). Again, staff advised that most detainees declined to avail of the offer of a nicotine substitute. Custody Visitors also confirmed this to be the case.

3.39 Detainees were offered one or more breakfast bars or, in some suites, a hot breakfast in the morning and a hot meal chosen from a selection at lunch and dinner time. Food that catered for the needs of vegetarian, kosher and halal diets were available. Tea, coffee and water were provided in between meals in most cases, although some CDOs were reluctant to provide a hot drink in case the detainee threw it at them. CDOs had been trained in food hygiene and were responsible for warming the ambient microwave meals in a kitchen provided for the purpose.

3.40 Ninety-three percent of detainees in our survey confirmed that they were offered something to eat and 98% something to drink (compared to 83% and 85% in 2009) and whilst 88% confirmed it was suitable for their dietary requirements only 21% rated it as very good or good. Staff confirmed a large amount of food was disposed of as detainees declined to eat it. Some staff and Custody Visitors felt that the breakfast bars were inadequate, particularly for detainees of heavier build. If detainees were held for more than 24 hours and the station had a canteen on site, then custody staff could purchase a hot meal as an alternative or solicitors could bring in a hot meal for the detainee. In one example in the custody records review it was recorded that staff had purchased a pizza for a young female detainee with her own money.

3.41 Five of the suites visited had an exercise yard, although staff reported that these were not used very often. Reading material was available in some suites and Custody Visitors confirmed they had seen this given to detainees, although this was also not in common use. Facilities made it difficult for detainees to

be offered visits, given the limited space in most suites, but staff in some confirmed that children could be visited by their parents, subject to a risk assessment. It was highlighted to Inspectors by custody staff that, although most suites had the required Home Office facilities, there was generally a lack of facilities for detainees held over 24 hours.

> An adult male, aged between 50 and 59 years, was arrested and held in custody for between two and three days. He was allowed to telephone his sister during this time and the custody record indicated that she brought in a change of clothes and some toiletries for him. He stated that there was no toilet paper in his cell and that he had to ask several times for a shower and was allowed to have one on his second day in custody. The custody record indicated that he was given something to read during his time in custody.

Individual rights

4.1 The area of the framework dealing with individual rights includes expectations relating to:

- appropriate, authorised and expeditious detention;
- appropriate access to solicitor/appropriate adult/interpreting service for interview/advice;
- adhering to rights relating to PACE;
- effective mechanisms for ensuring continuity of evidence;
- prompt appearance in court/video link; and
- facilities for detainees to make a complaint.

Rights relating to detention

4.2 Custody Officers spoken to indicated that in the vast majority of cases, arresting Officers were able to explain their rationale for requesting the authorisation of detention for an offence from the Custody Officer (the necessity criteria) and that this was usually appropriate and authorised. In most cases they felt that arresting Officers did their best to act expeditiously in progressing further enquiries in order to arrive at a point where the detainee could be charged, released or bailed. Just under half of detainees who participated in the survey confirmed they had been held for more than 24 hours (43%), a reduction from 2009 (69%).

4.3 Difficulties sometimes arose where arresting Officers were still available as a callsign to attend other requests for police from the public and therefore could get waylaid dealing with other incidents. In Strand Road there was a Process Team in place who took over the investigation process from arresting Officers, which custody staff highlighted as having a major positive effect on the timeliness of the investigation process. The availability of interview rooms was also raised as an issue on occasion that could delay the investigation process. Inspectors were advised that the number of interview rooms conformed to Home Office guidance, however this emphasises the need for careful demand modelling in determining the facilities to be made available in new builds or refurbishments.

4.4 Issues were also raised about the continuing use of tape recording equipment in interview rooms, which caused delays and sometimes technical problems. Estates Branch confirmed that the move to digital

recording equipment was a feature of the custody refurbishment and new build proposals. In response to a member's question at the 5 November meeting of the NIPB, the Chief Constable confirmed that digital interview recording was being introduced in the PSNI for PACE interviews with a target completion date of April 2016.

4.5 Reviews of detention before charge by the Duty Inspector were usually conducted over the telephone. Custody staff felt that this worked well and that most Inspectors were aware of the time that reviews would be due and therefore were proactive about undertaking them. Reviews by a Superintendent were rarely required and by a District Judge even less frequently, primarily only used in terrorist or other very serious cases.

4.6 Section 41 of the Terrorism Act 2000 (TACT) empowers a Police Officer to arrest without warrant a person whom he or she reasonably suspects to be a terrorist. A terrorist is defined by TACT as a person who has committed specified terrorist offences or a person who *'is or has been concerned in the commission, preparation or instigation of acts of terrorism'.* In 2013-14 there were 168 persons arrested under Section 41 TACT and of those 32 (19%) were subsequently charged. The NIPB, in its Human Rights Annual Report 2014[26] highlighted that this *'represents the fewest number of persons charged subsequent to a section 41 arrest in the last 10 years'.*

4.7 The Policing Board report also cited the 2013 Annual Report of the Independent Reviewer of Terrorism, David Anderson QC[27] who commented on the low charging rate for those detained by the PSNI under the Terrorism Act 2000 in 2013. As a result the Policing Board recommended that the *'PSNI should review its policy and practice in respect of arrests under section 41 of the Terrorism Act 2000 to ensure that Police Officers have not reverted to using section 41 Terrorism Act 2000 in cases in which it is anticipated that the suspect is more likely to be charged under other legislation. The review should be completed within six months of the publication of this Human Rights Annual Report. Within one month of the conclusion of the review the PSNI should report to the Performance Committee on the findings of the review and if required the steps the PSNI proposes to take'.* CJI awaits the outcome of this review with interest.

4.8 The use of custody suites for the detention of immigration detainees had decreased significantly since the opening of the Larne House Short-Term Holding Facility by the United Kingdom Border Agency (now Border Force) in 2011. Where Custody Officers had experience of working in custody suites which had held immigration detainees they confirmed that Immigration Officers conducted their investigations expeditiously and that detainees were quickly transferred to Larne House. Similarly, the numbers detained by Her Majesty's Revenue and Customs officers were very low.

4.9 PACE (Northern Ireland) Code C makes provision for the role of the appropriate adult in the case of a juvenile or a person who is mentally disordered or mentally vulnerable. In many cases this role is performed by a parent, relative or guardian if they are deemed to be appropriate by the Custody Officer (for example, if they are not a victim or witness or are suspected of involvement in the offence). In respect

26 Human Rights Annual Report 2014: monitoring the compliance of the Police Service of Northern Ireland with the Human Rights Act 1998, NIPB, 2014.

27 The Terrorism Acts in 2013: report of the Independent Reviewer on the operation of the Terrorism Act 2000 and Part 1 of the Terrorism Act 2006, David Anderson QC, 2014.

of young people, social workers may perform the role of appropriate adult where they are involved with the child and the parent is not deemed suitable or is unwilling to perform the role. However during the inspection the availability of social workers in cases involving looked after children was highlighted as an issue when young people were arrested, particularly when this occurred out of hours.

4.10 The Northern Ireland Appropriate Adult Scheme was provided by Mindwise for those under the age of 18 and vulnerable adults who were detained in police custody and did not have a suitable relative or guardian or who did not have a social worker involved with them. Custody Officers gave examples of situations where they would deem a relative or guardian of the detainee to be unsuitable to act as an appropriate adult and would therefore request one from the Scheme. Eighteen individuals who participated in the detainee survey required the services of an appropriate adult and all 18 confirmed one was present when they were interviewed.

4.11 Custody staff were positive about the service provided by the Appropriate Adult Scheme and said that in general, arrangements worked well. The Appropriate Adult Scheme received 2,185 requests in 2013-14, a 13.5% increase on the previous year. This figure included all requests for service, not just those where the suspect had been arrested and detained, but gives an indication of the growing demand for such a service.

4.12 1,359 of these were planned calls where Scheme members were scheduled to arrive at a specific time. In the custody environment this could be following an examination by a FMO, the morning after an arrest if a detainee was under the influence of alcohol or drugs and therefore unfit to be interviewed or to enable a detainee to have a period of rest overnight. Some of these calls would also relate to occasions where the suspect is scheduled to attend the police station at a later date for interview, for example after a period of police bail. A total of 826 (38%) were 'unplanned' calls where an appropriate adult was requested to attend a custody suite without any advance notice. In 790 (95.6%) of these, immediate requests a member of the Scheme arrived within two hours.

4.13 Of the requests received by the Appropriate Adult Scheme 80% related to requests to assist a person with a 'mental vulnerability' (for example a learning difficulty, mental health issue, literacy difficulties etc.) and 20% being vulnerable due to their age. In the custody record review there was evidence of a male child (aged 16 or younger) having their mother in attendance to act as an appropriate adult and another young man (aged between 17 and 21 years) having a social worker attend as appropriate adult.

4.14 In May 2013 the DoJ launched the Registered Intermediaries Schemes pilot. These introduced communication specialists to assist vulnerable victims, witnesses, suspects and defendants who had significant communication deficits to convey their answers more effectively during police interview and when giving evidence at trial. At the time of inspection the Schemes were in operation in respect of all cases being heard in the Crown Court. The role of the Registered Intermediaries had been included in the PACE Codes of Practice C and H 2015 Edition.

4.15 Interpreting and translation services for those who did not speak English as their first language were available over the telephone and face-to-face by two service providers. In addition there was a service

available for those who were deaf or hard of hearing. Custody staff found these services valuable and were generally happy with the service provided. Again there were some difficulties occasionally experienced with response times in rural areas, particularly with certain languages where there may only be one interpreter in Northern Ireland who may have to travel a significant distance to the custody suite.

4.16 Custody suites also had documents outlining the detainees rights in a range of languages and some staff pointed to the use of Google Translate to communicate with detainees. Prompt cards could be used by custody staff and Custody Visitors to communicate with detainees. Two detainees who participated in the detainee survey confirmed that they required the services of an interpreter and that one was present during their interview. In the review of custody records there was evidence of two Romanian detainees being given a copy of their rights in Romanian and having a Romanian speaking interpreter requested and attending promptly. The interpreter was requested on the afternoon of the day of arrest and then attended for interview the following morning at 10am.

Rights relating to PACE

4.17 Detainees were asked if they wished to request the services of a legal representative during the booking in process. For those that did not have a pre-existing relationship with a solicitor the Custody Officers were able to provide a list of local solicitors from which they could select one and in Belfast there was a Duty Solicitor Scheme. In the detainee survey 49 detainees (89%) confirmed they were offered free legal advice. Thirty-five (97%) of those who said they were interviewed and asked for a solicitor confirmed that one was present during the interview. During the custody suite visits Inspectors saw evidence of detainees consulting with their solicitors prior to interview.

4.18 Detainees are entitled, under PACE, to have someone concerned for their welfare, informed of their whereabouts, and consult a copy of PACE. In the detainee survey 40 detainees (78%) confirmed that someone was informed of their arrest. Thirty-eight detainees (69%) were offered a free telephone call and of the 12 that stated their telephone call was denied, two confirmed that a reason was given for this. Inspectors saw evidence in the custody records of detainees having telephoned family members.

4.19 In the survey 42 detainees (76%) stated that they were told of their rights when they first arrived and 31 (56%) recalled being told about PACE. Inspectors saw evidence of detainees having been given a copy of the PACE Codes of Practice during the visits although noted that this was a lengthy document, which could be difficult for some detainees to read. Whilst the role of the appropriate adult is to assist detainees in understanding this document it could be off-putting for the detainee if this is not explained to them.

4.20 Inspectors saw evidence that the FMO was required to review detainees who had been under the influence of alcohol or drugs and declare them medically fit prior to interview by Investigating Officers. Custody Officers stated that all solicitors requested a copy of their client's custody records and reviewed it prior to the interview commencing. No detainees in our survey raised any concerns about the interview process.

4.21 Previously CJI has raised concerns about the processes for ensuring the continuity of evidence.[28] In the custody suite this has specifically related to the submission and management of DNA and forensic samples. As a result of issues identified in the 2009 inspection, the report reiterated recommendations 20 and 23 from CJI/HMIC's 2005 report on scientific support services in the PSNI, in terms of the PSNI's responsibilities regarding forensic evidence:

- *Recommendation 20: Continued monitoring and action on quality control and continuity of evidence issues is necessary to ensure that trends and patterns within the Police Service are identified and actioned; and*
- *Recommendation 23: Exhibits and samples should be correctly packaged and labelled as any errors will result in delays.*

In this inspection CJI were pleased to find a much improved situation in respect of the storage of DNA and forensic samples in fridges and freezers in the custody suites. Custody staff confirmed that samples were collected from the fridge in the suite on a weekly basis for onward transportation to being processed.

4.22 Where issues were identified these were minimal in number and in one suite there was evidence that the CDO had made their best efforts to have out-of-date samples destroyed or removed. This is clearly an issue that local management will always need to maintain a focus upon in order to ensure that samples are processed in a timely manner.

4.23 Local Police Officers were responsible for transporting detainees from the custody suite to the local court and custody staff therefore ensured that the detainees were woken, given something to eat and drink and appropriately processed to enable them to arrive at court at the correct time. On weekdays this worked sufficiently but issues were raised about the early cut-off times for Saturday courts. Inspectors were advised that it could be difficult to have a detainee ready for court on a Saturday morning by the cut off of 10.30am at the latest, particularly those who had been arrested on Friday night under the influence of alcohol or drugs. In these cases the detainee would have to be declared fit for interview by the FMO in the morning, then interviewed by police with their solicitor present, as well as potentially an appropriate adult or interpreter, before being charged and transported from custody to court. If the deadline for attendance at court had been missed this then meant the detainee would be held in custody until Monday morning.

4.24 The creation of a single territorial jurisdiction for the County Courts and Magistrates' Courts in Northern Ireland was included in the Justice Act (Northern Ireland) 2015. This meant that a detainee would be taken to the most suitable court closest to the custody suite in which they were detained rather than the court area in which the offence was committed. This was a positive step in enhancing the efficiency of the process and reducing the travel time for both Police Officers and detainees.

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28 A review of scientific support services in the Police Service of Northern Ireland, CJI and HMIC 2005;
Scientific support services in the Police Service of Northern Ireland: a follow-up review of the inspection recommendations, CJI 2007;
Scientific support services in the Police Service of Northern Ireland: second follow-up review of the inspection recommendations, CJI 2008; and
Scientific support services in the Police Service of Northern Ireland: third follow-up review of the inspection recommendations, CJI and HMIC 2009.

4.25 The PSNI had been working with the NICTS to look at how they could improve the alignment between police and court processes. One example of how this had worked previously was when later start times had been arranged for courts to cope with the increase in numbers of detainees in custody arising from the flag protests in 2014. Further work was planned in this area involving discussions between the PSNI, NICTS, DoJ and Office of the Lord Chief Justice. Inspectors look forward to the outcome of these discussions.

4.26 Antrim custody suite had a live link facility which could be used for detainees arrested and held in the Serious Crime Suite. This had been used to request a warrant of further detention from a Magistrate on a few occasions in respect of detainees arrested under TACT and was reported to work well but was not in common usage. Section 50 of the Justice Act (Northern Ireland) 2015 allowed for the use of live link for first appearances from police custody on a Saturday, Sunday or public holiday. Any initiative that reduces the need to escort detainees from custody suites to courts is to be welcomed in terms of the benefits it offers in reducing resources and risks to both detainees and staff.

Rights relating to treatment

4.27 As outlined above the OPONI was responsible for dealing with complaints made in police custody and patterns and trends of complaints were shared with senior managers across the PSNI. Most complaints related to treatment of detainees by arresting Officers rather than custody staff. Nineteen (35%) of detainees who completed the survey stated that they had been told how to make a complaint about their treatment. Custody Visitors confirmed that they could ask for a detainee to be provided with a leaflet about the Ombudsman if they informed them that they wished to make a complaint. The PSNI were consulting on an updated Service Procedure for handling complaints which included how to record complaints made in police custody and share information with detainees on the role of the Police Ombudsman.

Healthcare

5.1 This area of the framework dealt with the provision of healthcare to detainees and includes expectations relating to:

- detainees cared for by healthcare professionals and substance abuse workers who have the appropriate training and skills, in a safe, professional, and caring manner that respects their decency, privacy and dignity;
- clinical governance;
- regular maintenance, checking of and training on equipment;
- infection control and forensically clean facilities;
- appropriate medical record keeping and assessment;
- safe and secure storage and disposal of medications;
- access to a healthcare professional at any time and appropriate treatment;
- access to prescribed medication;
- appropriate diversion into mental health and drug/alcohol services; and
- custody is not used as a place of safety for Section 130 of the Mental Health (Northern Ireland) Order.[29]

Governance

5.2 In 2009 Inspectors recommended that the PSNI should undertake a cost-benefit analysis of the current and alternative custody healthcare models, and implement the most appropriate and cost effective model, which was managed and monitored by appropriate PSNI representative(s). The report of the follow-up inspection in 2013 indicated that a cost-benefit analysis had been completed and approved by the Local Crime and Governance Board and the Healthcare Governance Board.

5.3 The Head of Custody Healthcare provided information on Phase 2, which was a business case for the provision of healthcare in custody suites. However this could not progress until a change was completed to PACE Code of Practice C by the DoJ (to enable the deployment of other appropriate 'healthcare professionals' rather than just a FMO). Publication of this amended PACE Code of Practice C in 2014 enabled the PSNI to arrange meetings with the DHSSPS regarding their role and support in the future relating to custody healthcare.

29 Section 130 of The Mental Health (Northern Ireland) Order provides that if a Constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the Constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.

5.4 The Custody Healthcare Reform Programme resulted in a detailed review of custody healthcare in terms of financial, contractual and clinical governance issues. In June 2012, as part of this programme the FMOs engaged by the PSNI individually came under a standard generic contract, in line with British Medical Association pay rates. However, while this provision has never gone through a formal tendering process, expenditure was regularised through a special Direct Award Contract (DAC). An extension to this ensured that DAC approval was in place until 31 March 2017. This is essential in the short-term for the PSNI to regularise FMO expenditure and allow the PSNI resources to be prioritised towards progressing the exploration of Custody Healthcare between the PSNI and DHSSPS.

5.5 At the time of inspection work was ongoing to develop a Joint Healthcare and Justice Strategy, which provided the opportunity for the PSNI to actively engage and develop meaningful partnerships with colleagues within both justice and health. A timescale for the completion of this strategy, a recommendation of the Prison Review Team report,[30] was being taken forward by the DoJ and DHSSPS. Working together allowed for the identification of areas of silo working, which could result in inherent risk, duplication and missed opportunities. The PSNI welcomed the support of health colleagues and the PSNI had been actively engaged with the Director of Service Delivery, DHSSPS (appointed by the Minister of Health to explore commissioning with the PSNI). A joint benchmarking visit had been undertaken to England to introduce health colleagues to a police custody healthcare model that was commissioned and provided by the NHS.

Strategic recommendation 3

Inspectors recommend that there is a firm timescale developed for the completion of, and the subsequent delivery of a more effective alternative custody healthcare model for police custody suites.

5.6 A team was in place to manage the custody healthcare service. The healthcare lead managed the FMO service provision and was reviewing how healthcare could be further developed assisted by the Programme Lead Change Manager. Inspectors were informed that another team member was to be appointed to take the lead for contract management. A PSNI Inspector had been designated to lead on the area of risk management, incident and near misses within custody. Healthcare is an area where the next concentrated piece of work is required.

5.7 The follow-up inspection report of 2013 identified that on 23 June 2010, the Northern Ireland Assembly enacted legislation entitled The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010. The regulations stated that every doctor is required to have a named Responsible Officer. The Responsible Officer is a statutory position who makes revalidation recommendations to the General Medical Council (GMC) concerning doctors linked to their organisation. At the time of the follow-up review no action had been taken to nominate or appoint a Responsible Officer for the FMOs contracted by the PSNI in accordance with these regulations.

30 Review of the Northern Ireland Prison Service: conditions, management and oversight of all prisons: Final Report October 2011, Prison Review Team 2011.

5.8 Inspectors found in this inspection that a Royal Colleges Responsible Officer was in place for each doctor and the PSNI were more involved in the appraisal of FMOs. Contact was also maintained with the Chief Responsible Officer. During discussions FMOs advised that they received yearly appraisals as part of their practicing General Practitioner (GP) role or through the Northern Ireland Medical and Dental Training Agency and further appraisals were signed-off by the designated PSNI Officer. Revalidation with the GMC occurred every five years. The PSNI planed to implement a 360 degree feedback for FMOs, including direct feedback by peers, work colleagues, and supervisor(s), as well as a self-evaluation. It could also include, in some cases, feedback from external sources, such as customers and suppliers or other interested stakeholders.

5.9 The AFMONI re-elected the Belfast Lead FMO as group chair at its annual general meeting. As part of healthcare reform the PSNI were exploring the future role of a clinical director to take forward the healthcare agenda. Inspectors noted that clinical governance needs to be strengthened for the FMO service as variations in practice across Northern Ireland were observed. Examples of these are illustrated, particularly in relation to medications management.

Strategic recommendation 4

Clinical governance arrangements need to be standardised and strengthened for the FMO service across Northern Ireland.

Training

5.10 Training was provided in various formats, for example via email or online courses. Inspectors were advised that yearly training on resuscitation equipment was provided. With the exception of one staff member, Custody Officers and CDOs advised that they had received no training on dealing with blood, body fluids or sharps. PSNI trainers stated that custody staff received sharps training as part of health and safety search training. Staff had also received 'safeTALK' training which covered suicide awareness. Applied suicide intervention skills training (ASIST) has been carried out in Belfast as part of a local initiative training; all custody sergeants in Musgrave custody suite had been trained.

5.11 Trainers advised that there were no specific courses on mental health. When in post the community mental health nurse delivered mental health awareness training for staff, which was seen as beneficial. At the time of inspection PSNI trainers fulfilled this role. Mindwise had also provided an input into the training course for Custody Officers and some individual Officers had undertaken mental health or suicide awareness, but CDOs in particular felt they could benefit from more training in this area. Custody Officer update training included deaths in custody, care planning, health and safety and half day training with the Lead FMO for Belfast.

5.12 FMOs advised that they had received basic life support training as part of their GP role. Inspectors were advised that as part of the requirements of the Faculty of Forensic and Legal Medicine (of the Royal College of Physicians) FMOs required immediate life support training. FMOs were keen to undertake this training and the Northern Ireland Ambulance Service had been approached to carry this out. The

PSNI was in the process of developing a version of the New to Forensics Programme, accredited with the Scottish School of Mental Health, for police in conjunction with the Bamford Training Needs Analysis.[31] This is to assist police in identifying and dealing with mentally disordered persons. Additionally, the PSNI had identified, with the Public Health Agency, a mental health first aid course for their Officers.

Operational recommendation 1

It is recommended that custody staff receive healthcare training commensurate with their role, including:

- **training on infection prevention and control including the management of blood/body fluids;**
- **the implementation of training for the identification and management of detainees with mental health needs;**
- **further development of ASIST training; and**
- **immediate life support training for FMOs.**

Medical equipment, environment and infection prevention and control

5.13 The inspection found that money had been spent on improving medical suites, for example in relation to the furniture, equipment and keys. The majority of medical rooms inspected were clean and uncluttered, equipped to the required standard and afforded an appropriate level of privacy and decency. There was variation in the general cleanliness in Strand Road and Dungannon and Lurgan were in need of refurbishment.

5.14 The contract for domestic cleaning should be more closely monitored. For example, domestic stores and equipment required more in-depth cleaning and organisation. In some suites equipment used for cleaning was dirty, mops were found steeping in dirty water and the knowledge of cleaning products and practice was variable. Inspectors found that there was variation in when supervisors would visit or carry out spot checks in the custody suites.

5.15 An out-of-hours cleaning service was available, however use was dependant on directives from senior PSNI staff. Custody staff also highlighted that on occasion, over bank/public holidays there were difficulties in accessing out of hours cleaning services; on one occasion cells had to be closed. Only Musgrave custody suite had a 24/7 cleaning service.

5.16 Inspectors were informed that custody staff had access to a 'bio kit'; to absorb small body fluid spills to prevent cell closures. The PSNI were also reviewing the levels of cleaning required and the cleaning products used as these had in the past caused problems for the fabric of the building. There remained issues regarding cleaning above head height as this was not part of the current cleaning contract. ***The contract for domestic cleaning should reviewed and monitored to ensure that the service is fit for purpose.***

31 A comprehensive legal framework for mental health and learning disability, The Bamford Review of Mental Health and Learning Disability Services (Northern Ireland) 1997.

5.17 Inspectors found that the checking of resuscitation equipment was good and the records were signed by custody staff on a monthly basis. In one custody suite improvement in this area was required, which was mainly due to the lack of an identified responsible person. The contents of the first aid boxes required review as there was no standardised list of contents and some equipment was out-of-date. Inspectors were informed that a list of first aid items, specifying what should be held in custody suites, was being drawn up and was to be shared with Estates, Procurement and Health and Safety Branches. This was to be completed by March 2015 but the inspection evidenced that this had not been achieved. ***The items in first aid boxes should be standardised and a responsible person identified to ensure contents are checked regularly.***

5.18 Large bags of resuscitation equipment had been purchased for the G8 Summit, but not been utilised. These were a good resource but a decision regarding the further use should be made as Inspectors found out-of-date medication and sterile equipment within them.

5.19 Inspectors noted a variation in the provision and use of Personnel Protective Equipment (PPE). In some suites only gloves were available or used, whilst in a few suites, full body protection was available for use. Inspectors were informed that this area was being reviewed as consistency in supply and use was needed. There were issues to be resolved regarding sufficient time to put on PPE and variations with what Business Managers purchased. Custody staff raised the issue of detainees spitting at them, which had been brought to the attention of senior management but had not been resolved. It would be advisable if the PSNI could investigate what equipment was in use in other police forces or public services in order to introduce a safe and effective form of equipment to protect staff from spitting.

5.20 Issues remained with the clinical waste contract. The bags used for the disposal of clinical waste were orange; the colour used in England but not in Northern Ireland. In most cases sharps containers were wall mounted in a locked outer casing. The key for these was unavailable, therefore Inspectors were unable to check if boxes were labelled, dated and signed, however again sharps boxes were found which were not in the sealed container and not correctly labelled. Sharps boxes must be labelled and signed by staff when assembling and disposing of. Correct labelling ensures that if there is a spillage of sharps waste from the sharps box or an injury to a staff member as a result of incorrect assembly or disposal, the area the sharps box originated from can be immediately identified. Identifying the origin of the sharps box and its contents is imperative to assist in the immediate risk assessment process carried out following a sharps injury and also to ensure that staff who incorrectly assembled or disposed of the sharps box can receive education on the correct procedures to follow.

5.21 Domestic fridges were still used for storing medication such as insulin. Inspectors found that in some suites these were unlocked and temperatures not checked. It is important that fridge temperature checks are taken and recorded on a daily basis to ensure medication is stored at the correct temperature and to identify any failures in the cold chain. Some insulin pens stored in the fridges were out-of-date. ***Infection prevention and control precautions should be adhered to.***

Patient care

5.22 There was evidence of respect for the decency, privacy and dignity of detainees to the level that can be achieved in a custody environment. Ninety-four percent of the respondents to the detainee survey reported seeing a doctor whilst in custody. Of those prisoners who had been seen by healthcare staff, 65% in comparison to 41% in 2009 reported that the quality of healthcare was good or very good.

5.23 Custody staff were able to request the services of the on-call FMO in and out-of-hours. Generally access to FMOs was good although Inspectors were informed that in some areas, mainly rural, there could be delays. This was mainly where the on-call FMO covered several suites or were also practicing GPs and undertook duties in their surgery as well as FMO duties.

5.24 Records of contact with healthcare professionals, outlining the assessment and care required for the detainee were kept, via the PACE 15 form. These were attached to the detainee's custody record. Custody records also contained direction on treatment and care of detainees and a record of medication provided. However, during this inspection, FMOs advised that the section on the PACE 15 form in which to record clinical assessment was insufficient and that the body chart in use could be improved, in line with the body chart on Niche RMS. Although, this had been identified to the PSNI, updating documentation had not progressed.

5.25 As in the follow-up review published in 2013, issues with record confidentiality were identified. In two medical rooms records, including FMO statements of the incident, were not locked away and were easily accessible. Inspectors identified variation in the storage of PACE 15 forms. In several cases current and retired FMOs personally retained carbon copies in filing cabinets or scanned and encrypted them onto a laptop. It was also advised that one FMO disposed of records. This is not in line with PSNI, Caldicott[32] and professional guidance.[33] FMOs advised that over time the PACE form books degrade. A healthcare section was present on the Niche RMS, but was not utilised. The recording and storage of records should be reviewed to ensure consistency and confidentiality and archiving should be explored.

5.26 At the time of the inspection the custody healthcare team were introducing the electronic care records system. This would enable FMOs to have access to information on the detainees prescribed medication and allergies from their GP record. This system was in place in Musgrave Street but was not yet 'live'. Collaboration between the systems manager and the PSNI is required before this can progress and electronic care records rolled out across all custody suites. Information sharing policies, to ensure efficient sharing of relevant health and social care information, are part of the custody healthcare reform. These should be progressed within policy development.

Operational recommendation 2

The PSNI, in line with current guidelines, review and update practices and policies in place for healthcare records management. Information sharing policies should be developed.

32 The Caldicott Committee: report on the review of patient-identifiable information, Department of Health 1997.
33 Records management: NHS Code of Practice, Department of Health 2006.

Mental health and addictions

5.27 At the time of the fieldwork formal liaison or diversion schemes to enable detainees with mental health issues to be diverted into appropriate mental health services had not been finalised. Corporately, the PSNI had drafted a Regional Inter-agency Protocol on the Operation of Place of Safety and Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986. This protocol was awaiting approval by the PSNI, the Northern Ireland Ambulance Service and the Health and Social Care Trusts.

5.28 In June 2014 the PSNI submitted an analysis of police delays at emergency departments to senior officials in the DHSSPS and the Health and Social Care Board. The Board undertook an investigation into the circumstances leading to delays in those cases and was in the process of disseminating lessons learned. However, the current challenges faced by the emergency departments in terms of sheer volume will continue to impact on the PSNI.

5.29 The PSNI Service Improvement Department links the police and Health and Social Care Trust counterparts locally. Police from Belfast City Policing District were meeting with counterparts at the Royal Victoria Hospital to address local issues of concern. The PSNI hoped to replicate this model across all PSNI districts and Trusts.

5.30 Local arrangements existed between custody suites and local healthcare providers, but these were not always sufficient. Recently the pilot projects involving two Community Psychiatric Nurses and Drug Alcohol Referral Teams have been withdrawn. This was a retrograde step given the needs of the detained population. During fieldwork for the follow-up review published in 2013, Inspectors were told that a review of the service had recently been undertaken but that the Community Psychiatric Nurses were not aware of the outcome. In both 2009 and 2013 Inspectors found that Community Psychiatric Nurses in Musgrave Street offered a much needed service. At the time of this inspection the PSNI were reviewing the mental health needs of the detainees and identified that 35% of detainees claim they have mental health needs. In our survey 37% detainees identified that they had mental health needs. Work was ongoing with the DHSSPS who had agreed that once new policing structures were in place the District Superintendents, with responsibility for custody, would have links with the hospitals in their district.

5.31 The consultation on the Mental Capacity Bill for Northern Ireland by the Health and Justice Ministers, regarding proposals for new mental capacity legislation in Northern Ireland, opened in May 2015. The draft Bill was intended to give effect to a major recommendation arising out of the Bamford Review of Mental Health and Learning Disability Services in Northern Ireland.[34] The PSNI were reviewing this to identify issues, risks and potential human rights breaches.

5.32 During fieldwork for the follow-up review published in 2013 there were still three Drug Arrest Referral Teams in Belfast, Derry/Londonderry and Ballymena. At the time these remained as a DoJ Community Safety non-recurring funded project. These schemes finished when funding was stopped in 2014. In our survey 31% of detainees stated that they had drug or alcohol problems.

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34 A comprehensive legal framework for mental health and learning disability, The Bamford Review of mental health and learning disability services (Northern Ireland) 1997.

Return to contents

5.33 All custody staff stated that there were now more detainees with alcohol, substance misuse and mental health issues. Some staff stated that access to mental health services out-of-hours could be problematic and detainees could travel some distance to be seen. In some areas there had been recent improvements and mental health staff would come into the custody suite.

5.34 In Emergency Departments detainees could wait long periods to be seen. Delays at emergency departments continue to have an effect on the ability of police to respond to other demands. It can be difficult for Police Officers to differentiate between a mental health problem or an alcohol or drug induced psychosis. To help address this the PSNI was engaged in partnership with Health and Social Care Trusts to address delays when persons are brought to emergency departments and was working on awareness training to provide Officers skills in identifying persons in mental health crisis.

5.35 Through national benchmarking the PSNI had identified best practice that they would wish to see introduced in Northern Ireland. These included:

- a purpose built place of safety (outside of police custody and the Emergency Department environment);
- street mental health nurse triage;
- Trust health services embedded in custody suites; and
- expedient pathways into emergency departments, for example, West Yorkshire Police undertake triage with the Emergency Department over the phone and receive a slot for mental health assessment as opposed to Officers having to wait at the emergency department.

5.36 In April 2013 the PSNI Reducing Offending and Safer Custody Branch issued a reminder to all custody suites that police custody should only be used as a place of safety in the most extreme cases and in each case a report must be submitted to the Head of Custody Healthcare. Since this reminder had been issued, a total of 47 reports had been submitted regarding the use of police custody as a place of safety.

5.37 In the draft Mental Capacity Bill it was proposed that the existing definition of a place of safety, which included police stations, would be preserved with provision that a police station should only be used if no other suitable place is available. The consultation response document[35] highlighted that *'of the 25 respondents that commented directly on the DoJ's proposals for places of safety, over half raised concerns about the continued use of emergency departments and police stations as places of safety, including their use for those aged under 16. However support was expressed for the DoJ's proposal that a police station should only be used as a place of safety as a measure of last resort, provided that the power is carefully monitored and reviewed. A number of responses stressed the need for continued work around handover arrangements between the police and healthcare staff at emergency departments and the requirement to provide clear guidance for staff in a Code of Practice'.* The Performance Committee of the NIPB was one of those respondents who expressed its concerns with this approach and stated that it would welcome further consideration of this issue by both departments.

35 Draft Mental Capacity Bill (Northern Ireland): Consultation Summary Report, DHSSPS, 2015. Accessed online at http://www.dhsspsni.gov.uk/mental-capacity-bill-consultation-summary-report.pdf.

5.38 As part of the fieldwork for this inspection CJI visited The Nightingale; a service developed by FASA[36] that aimed to provide a 24/7 crisis centre for people who find themselves or a family member impacted by a mental health incident with nowhere to turn. FASA had held discussions with the DoJ and DHSSPS with a view to having The Nightingale designated as a place of safety. Inspectors welcome any initiatives which aim to provide alternatives to the use of police custody as a place of safety.

5.39 In view of the challenges outlined above for custody staff in dealing with detainees who have mental health issues or are have alcohol or drug problems it is recommended that:

Operational recommendation 3

Formal links with Trusts and police custody should be finalised, with equity and standardisation regionally for those with mental health and addictions needs.

Detainees receive prescribed medication if needed

5.40 At the time of inspection the designated PACE medical rooms visited had secure and locked metal wall mounted drugs cabinets. Access to the drugs cabinet was only allowed by FMOs. Since the last inspection, a new system had been introduced whereby the key to open the drugs cabinet was stored in a wall mounted keypad box. The access code for this box was known only by the FMOs. However, on one occasion, Inspectors were able to gain access to the drugs cabinet as custody staff were aware of the code and opened the keypad box.

5.41 Senior designated FMOs were responsible for pharmaceutical stock management including the reviewing and ordering of medication. Inspectors found illegible stock books and disorganised drugs cabinets. On one occasion, Inspectors found out-of-date diazepam (dated use by 2012) and dihydrocodeine (use by 2008). Where drugs fridges were present there was no temperature checks evident. On one occasion, out-of-date insulin (dated use by 2014 and 2015) and a flu vaccine was observed. On another, insulin pens were stored in the door of a fridge used by the PSNI to store blood samples.

5.42 Since 2009, there continues to be no clear audit trail or record of medication stock usage. In some areas, pharmacy delivery receipts were present. Inspectors were advised that a pilot audit had been carried out by a FMO, which had proved difficult to complete. Inspectors suggest that an audit is carried out in the first instance for higher risk divertible medications, for example, diazepam.

5.43 Concerns remained over the administration of medication and storage of medication not consumed. Adequate clinical assessment of the detainee should be carried out prior to prescribing and administering medication. Variation was identified in FMOs response to detainees requests for prescribed medication. This ranged from checking with the detainee's GP, contacting the GP out-of-hours service prior to prescribing medication or asking the detainee to provide evidence of being prescribed medication, for example, a previously prescribed medication box with its pharmacy identification label in situ. FMOs

36 FASA (Forum for Action on Substance Abuse) is an organisation based in Belfast which provides specialised services in relation to substance misuse, suicide and self-harm. See www.fasaonline.co.uk.

felt that the introduction of electronic care records to assist with prescribing was a positive step in the prevention of medication errors. There continued to be no access to an on-call pharmacy. If a detainee's previously prescribed medication was not available it could be brought in by a friend or relative, with details as previously outlined.

5.44 Inconsistent medication dispensing was identified on observation and through discussion with staff. Medication for administration was dispensed into clear pre-printed polybags on which was recorded details of the detainee, doctor and medication for administration. On review of one dispensed medication, it was noted that the FMO did not complete the plastic bag correctly; with no FMO name, contact details or the detainees full name (only the surname) recorded. The Lead FMO for Belfast advised that FMOs should dispense all medications into one bag for each time of administration. This varied in practice, with medication being dispensed into a separate bag for each medication, as outlined in the draft AFMONI Custody Suite Medications Policy. Medication was dispensed as a single tablet or cut off from blister packs, meaning that details of the tablet were unable to be determined, for example, full name, dose, expiry date.

5.45 Medication was administered to the detainee by the FMO or custody staff from the pre-dispensed bags. It was again evident from discussion that custody staff have had no formal training or supervision on the safe storage, handling, administration and disposal of medication. Staff learned on the job from other staff and from FMO advice.

5.46 Locked wall mounted metal drop boxes were available for the disposal of medication which was out of date or not consumed. These were emptied weekly. Some FMOs advised medications not consumed, but within packaging, were placed back into the drugs cabinet for re-use. This has the potential for error, as previously outlined.

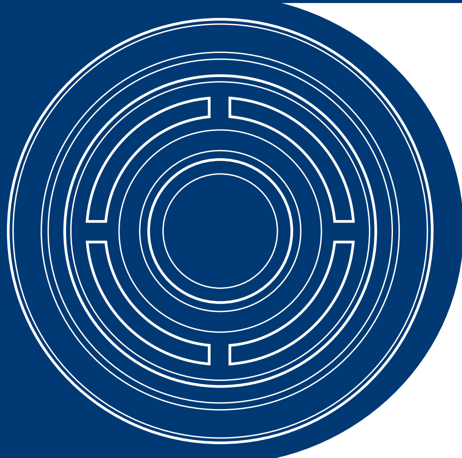
5.47 At the time of the inspection, custody staff recorded the administration of medication on the computer records system. In the future, the PSNI would like to implement the Egton Medical Information System; a medicines management system in use within prison healthcare.

5.48 Inspectors were provided with a draft copy of AFMONI Custody Suite Medications Policy. The final development of this policy remains outstanding from the follow-up review published in 2013. In January 2014, representatives from PSNI custody healthcare reform met with the Chief Pharmaceutical Officer's office regarding an ongoing programme of work for pharmaceutical governance and the significant risks around drugs being consumed in custody and the drug mixtures detainees were accessing. Work was to include standardisation of practice, drugs entering the country and an advisory inspection, yet to be carried out. The custody healthcare reform team acknowledged that further significant work is required to progress the area of medicines management.

5.49 This area requires immediate attention. It is concerning to again note that since the inspection in 2009 and follow-up in 2013 there has been limited progress in this area and the safe use and control of medicines cannot be assured. The recommendation from 2009 is repeated.

Strategic recommendation 5

It is recommended that the PSNI should urgently review its policies and procedures for the safe selection, procurement, prescription, supply, dispensing, storage, administration and disposal of medications. There should be a clear audit trail in place for the management of medications.



Appendices

Appendix 1: Inspection framework

Expectations for police custody

Criteria for assessing the treatment of and conditions for detainees in police custody

Adapted from Her Majesty's Inspectorate of Prisons and
Her Majesty's Inspectorate of Constabulary Expectations

Version 2, 2012

Section 1: Strategy

There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the wellbeing of detainees.

Expectation

1. There is a strategic focus, supported by the Chief Officer group, which promotes the safe and decent delivery of custody

Indicators

- There is a policy focus on custody issues at a chief officer level.
- There is an effective management structure that ensures:
  - appropriate policies and procedures for custody are in place and fully implemented;
  - custody delivery is proactively monitored against agreed standards and performance measures;
  - use of force, adverse incidents and complaints are proactively monitored locally and at service-wide level; and
  - there are partnership arrangements and constructive engagement, including at Criminal Justice Board level.

Evidence

Chief officer

- Ask if the policy focus includes:
  - developing and maintaining the custody estate;
  - staffing of custody suites with trained staff;
  - managing the risks of custody;
  - meeting the mental and physical health and wellbeing needs of detainees;
  - meeting the diverse needs of detainees - including vulnerable adults and safeguarding children; and
  - working effectively with commissioners and providers of health services, immigration services, youth offending services, criminal justice teams, Public Prosecution Service (PPS), courts and other law enforcement agencies.
- Ask:
  - about the oversight of the Northern Ireland Policing Board, independent custody visitors (ICVs) and other mechanisms – how effective and proactive is it?
  - what quality assurance procedures are in place; and
  - what the procedures are for monitoring the use of force, and whether use of force is monitored by diversity, location and the officer involved.

Documentation

Check:

- the minutes of custody manager meetings;
- the numbers of staff, gender balance, training, development and succession planning;
- the availability of management information on trends and patterns; and
- custody records for quality assurance and scrutiny.

References

BOP 1, 5, 29, 36(2); BPUF 1, 18–20, 22; CCLEO 2; CRC 3; ICCPR 10(1); JDL 85; OPCAT 4; RTWP 56
PACE Codes of Practice Code C 3.7

Section 2: Treatment and conditions

Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Expectation

Respect

2. Detainees are treated with respect and their diverse needs, while in custody, are met.

Indicators

- The diverse needs of detainees are met. This includes the specific needs of:
  - women;
  - black and minority ethnic detainees;
  - foreign nationals;
  - those with disabilities;
  - immigration detainees;
  - those with religious needs;
  - older detainees;
  - detainees of all sexualities;
  - transgender detainees;
  - those with dependency needs; and
  - those with obvious vulnerabilities.
- All custody staff recognise and understand the distinct needs of children and treat them accordingly.

Evidence

Custody officer and staff

Ask staff to describe their interaction with detainees. Specifically, ask:

- how the diverse needs of detainees are identified and assessed;
- how they address the diverse needs of their detainees, for instance if they understand the differential impact of detention on women;
- what training, including child protection awareness, they have had and what skills they have to deal with detainees' diverse needs;
- whether all custody and health care staff, including agency staff, have been vetted to work with vulnerable groups, including children;
- how they ensure children are kept separate from those who might pose a risk to them;
- whether all girls under the age of 18 remain in the care of a woman during detention as required under Section 9 of The Criminal Justice (Children) (Northern Ireland) Order 1998; and
- how and why they make referrals to youth offending teams.

Documentation

- Check custody records for evidence that the diverse needs of detainees are correctly identified and catered for. For instance, are searching procedures sensitive to gender, age, different religions, etc? Specifically, check:
  - children's custody records for recognition of their distinctive needs; and
  - the recording of any child protection concerns.
- Check:
  - that children are not held overnight without good reason;
  - that there are effective joint arrangements in place which cover the provision and accessibility of both secure and non-secure accommodation for those children who have been charged with an offence and had bail refused by police; and

- that legal requirements are being met in respect of children who have been charged with an offence and had bail refused.

Observation
Check:
- how staff talk to and about detainees in their care;
- that arrangements at the booking in desk allow sufficient privacy to disclose any vulnerabilities or for confidential information to be passed on to custody officers; and
- that reasonable adjustments have been made in line with equality legislation.

Detainees
- Ask if they feel they have been treated respectfully by staff; and
- Ask about their diverse needs and whether they feel these have been met.

References
Beijing 10.3, 12; BOP 1, 5, 36(2); CCLEO 2; CEDAW 2; CERD 2; CRC 3, 37, 40; CRPD 4; DEDRB 2; DHRIN 5; DRM 4; ECHR 8; ICCPR 2, 3, 10(1); JDL 1, 85; POP 17; RTWP 56
PACE Codes of Practice Code C 3(b) Detained persons - special groups

Expectations
Safety
3. Custody staff are competent to assess and manage risks presented by detainees.

Indicators
- Staff receive initial and refresher training in risk assessment procedures.
- Staff have a knowledge and understanding of self-harm and how to manage it.
- Staff have a knowledge and understanding of detainees' risk to others and how to manage it.
- Risk management plans are proportionate and are developed and reviewed dynamically.

Evidence

Custody officer and staff
Ask:
- about the normal procedure for assessing the risk detainees pose to themselves and/or others;
- what happens if a detainee is unwilling or unable to cooperate with the risk assessment;
- how high numbers of detainees coming into custody at peak times are managed;
- whether staff alert them if they are bringing a violent detainee into the custody suite and what arrangements are made;
- what the arrangements are for monitoring those assessed as a risk;
- whether staff understand the importance of regular monitoring and rousing;
- whether staff carry keys to cells and ligature knives at all times;
- if cells are checked thoroughly for any unauthorised items between use; and
- if prisoners' escort record forms are completed for all detainees to be transported, by whom and what information is passed on to escorting staff about those considered a risk to themselves.

Documentation
Check:
- the policy on cell sharing. Is cell sharing only authorised in exceptional circumstances and on the basis of a thorough risk assessment? and
- a sample of risk assessments.

Observation
Observe:
- assessment procedures on reception;
- whether actual checks are carried out at the cells, how often they are conducted and how they are recorded;
- whether the CCTV is working, whether it records and how long the recordings are kept;
- staff handovers for the sharing of risk information;
- cells and whether they are checked by staff for any unauthorised items between occupants;
- the skills and competence of staff;
- whether and how quickly detainees at risk are seen by healthcare staff; and
- that detainees' offence details are not on display for others to see.

Detainees
Ask those identified as at risk what level of attention they have received from custody staff.

References
BOP 1, 36(2); CCLEO 6; ECHR 2; ICCPR 6, 10(1); JDL 85; UDHR 3
PACE Codes of Practice Code C 3.6–3.10 and 8.1
SDHP Section 2

4. Pre-release risk management planning for detainees is conducted to ensure they are released safely.

Indicators
- Formal procedures are in place for pre-release risk assessment that acknowledge known risks and specify any actions needed.
- Any relevant information about risk, vulnerability or safeguarding is communicated to relevant agencies.

Evidence

Documentation
Check:
- custody records for evidence of pre-release risk management plans;
- that information about and the contact details for support organisations are provided and available in a range of languages;
- the processes for safeguarding children, including those aged 17; and
- the processes for communicating to relevant police departments or external agencies any information about risk or vulnerability.

References
BOP 1; CCLEO 2; CRC 3; ECHR 2; ICCPR 10(1); UDHR 3
SDHP 8.3

5. Any force used within a custody suite is proportionate and lawful.

Indicators

- Where force is used, staff use only techniques in line with training the PSNI has provided, with no more force and for no longer than is necessary.
- Detainees are examined by an appropriately qualified health care professional if requested, or if there are health care concerns.
- Use of force within custody suites, including the use of control and restraint equipment, is documented within the individual custody record and a separate 'use of force' form is submitted in line with Association of Chief Police Officers (ACPO) policy.

Evidence

Custody officer and staff

Ask:

- how they define use of force;
- what methods of restraint they think can be appropriately applied in the enclosed custodial setting: for example, what is the guidance on the use of incapacitant sprays, Tasers, etc?
- what methods of de-escalation they use before force is applied;
- in what circumstances they would apply force and how they make a decision about what level of force to use;
- if the consequences of and potential injuries resulting from different methods of force are recognised and taken into account;
- what alternative procedures are applied to those with a known health problem, children or with women who are known to be pregnant; and
- what training they have had in the use of force, when this occurred and whether they have had any refresher training.

Documentation

Check:

- the use of force guidance and whether consideration is given to the use of Tasers, incapacitant sprays, handcuffs, limb restraints and empty hand techniques;
- staff training records; and
- the use of force form and custody records. Look for evidence that a health examination took place after the use of force in custody, if appropriate, how quickly the detainee was seen after the use of force incident and the outcome of the examination.

Observation

Check CCTV recordings.

Detainees

Ask detainees if they have been subject to the use of force in custody.

References

BOP 24; BPUF 1, 2, 4–6, 15, 18–20, 22; CCLEO 3, 6; ECHR 3, 8
SDHP section 4

Expectation
Physical conditions
6. Detainees are held in a custody suite that is clean, safe and in a good state of repair.

Indicators

- All cells are equipped with call bell systems, detainees understand their purpose and they are responded to promptly.
- There are good maintenance arrangements.
- Cells are free from ligature points, or the risks they present are managed.
- There are practices for the use of cells with restricted natural light and facilities.
- Custody suite staff can safely evacuate detainees from the custody suite in the event of an emergency.

Evidence

Documentation
Check:

- the cleaning contract and schedules, and the policy on clearing up spills and graffiti;
- staff training records;
- the frequency of fire evacuation drills and their type;
- contingency plans; and
- records detailing the maintenance and testing of fire and smoke detection.

Custody officer and staff
Ask:

- how a decision is made about required maintenance work;
- what the maintenance procedure is and what impact it has on provision of custody;
- what excess custody capacity the PSNI has to allow suites to be shut so that essential maintenance can be carried out;
- what fire safety training they have received;
- how frequently fire evacuation drills are held and whether these are just desktop exercises or also include a practice evacuation;
- when the service last carried out a cell smoke test at each site;
- whether custody suites can be evacuated safely in emergencies, taking into account the physical security, the need for ready access to keys and the fact they may have detainees with disabilities; and
- what they would do in the event of a fire.

Observation

- Check holding areas, cells, interview and detention rooms and showers.
- Observe whether staff check cells before and after occupancy. Ensure that checks and findings/damage are recorded.
- Listen to what detainees are told about the call bells when they are placed in cell and how understanding is ensured, especially for those whose first language is not English and those with a disability, such as hearing difficulties or learning disabilities.
- Check that call bells are connected and working.

Detainees
Ask:

- what they were told they could use call bells for and if they understood;
- if they have used their call bell and how long it took for staff to respond; and
- if they find their cells clean, safe and in good repair.

References
BOP 1; CCLEO 2; ECHR 3, 8; ICCPR 10(1)
PACE Codes of Practice Code C 8.2
SDHP 7.10, 12.1.5 and 15.4

Expectations
Detainee care
7. Detainees are able to be clean and comfortable while in custody.

Indicators
- Detainees are provided with a mattress, pillow and clean blankets.
- Hygiene packs for women are available, and are routinely offered on arrival and on request.
- Detainees are able to use a toilet in privacy, and toilet paper and hand washing facilities are provided.
- Detainees who require a shower are offered the opportunity to do so.
- Detainees whose clothing is seized are provided with suitable alternative clothing, as soon as practicable.
- Changes of clothing, especially underwear, are facilitated.
- Nicotine replacement is provided by a health care professional to detainees on request and they are informed of this on arrival.

Evidence

Detainees
Ask if they need/have received the means to be clean and comfortable while in custody.

Documentation
Check:
- for the policy on mattress and pillow cleaning between uses;
- whether mattresses/pillows are checked for damage between uses;
- the protocol for bringing in clothes; and
- custody records.

Observation
Check:
- that there is sufficient privacy for those using integral sanitation;
- that toilet paper and hand washing facilities are provided in cell where integral sanitation exists;
- that detainees who require a shower are offered the opportunity to do so and are given clean and suitable towels for this purpose;
- that detainees can have a shower in private, and the arrangements for women and children;
- that a supply of appropriate alternative clothing is available (not paper suits) for detainees of different genders and age and for those at risk; and
- that adequate supplies of clean, undamaged bedding are available.

Staff
Ask:
- how detainees get access to the toilet if there is no integral sanitation;
- if the facilities are sufficient for the number of detainees held at any one time;
- if hygiene packs are available and offered to women;
- when alternative clothing was last used;
- about laundry and cleaning arrangements for bedding;
- if family/friends are able to bring in items of clothing for a detainee; and

- whether nicotine replacement is provided by a health care professional to detainees on request and whether they are informed of this on arrival.

Defence solicitors
Ask whether their clients are ever released in replacement clothing and what form this takes.

References
BOP 1, 24; CCLEO 2, 6; ECHR 3, 8; ICCPR 10(1)
PACE Codes of Practice Code C 8.3, 8.4, 8.5
SDHP 7.8.4, 7.8.1 and 6.6.3

8. Detainees are offered sufficient food and drink.

Indicators
- Detainees are offered food and drink at recognised mealtimes, and at other times that take into account when the detainee last had a meal and on reasonable request.
- There is a suitable range of food and drink available.
- Food and drink is of adequate nutritional value.

Evidence

Staff
Ask:
- when detainees are offered food and/or drink;
- what type of food is offered and how this meets special, including clinical, diets and religious requirements; and
- if further food can be supplied by friends and family.

Documentation
Check:
- custody records; and
- food hygiene training records for staff preparing food.

Observation
Check:
- whether detainees are asked at reception when they last had a meal/drink and offered appropriate refreshment;
- that food is prepared in a hygienic environment, that meets religious, cultural and other special dietary requirements;
- that food is healthy, balanced and there is enough of it;
- that a temperature probe is used to ensure food is of the correct temperature at the point of serving;
- that food is stored in fridges/freezers kept at the correct temperature and records are maintained of daily checks; and
- that detainees have access to drinks.

Detainees
Ask:
- when they have been offered suitable food and drinks; and
- what type of food was offered and whether this was sufficient.

References
BOP 1; CCLEO 2; ECHR 9; ICCPR 10(1); ICESCR 11
PACE Codes of Practice Code C 8.6, 8.9 and guidance note 8B

9. Detainees are offered outside exercise, reading materials and, in the case of children or other vulnerable detainees and those held over 24 hours, the opportunity to have visits.

Indicators
- Detainees have access to a period of outside exercise.
- They are offered suitable reading material.
- Visits are allowed, especially for those held for more than 24 hours or those under 18 years old.

Evidence

Staff
Ask:
- if detainees are allowed access to an exercise area and, if so, when it would be offered, if it is supervised and what the barriers are to its use. Ask what the arrangements are for men, women and children;
- if visits are offered and to whom;
- if parents or carers are able to visit detainees, especially children, particularly if they are held overnight; and
- what reading material they provide for detainees and how long after arrival it is offered. What is provided for those with learning difficulties, for example material in easy read format, and for those who do not speak English.

Documentation
Check custody records.

Observation
Check:
- whether there is an outdoor exercise area, and whether it appears to be used regularly;
- whether reading material is available and offered to detainees; and
- the visiting facilities.

Detainees
Ask if they have been offered anything to read/keep them occupied, and whether they have had the opportunity for outside exercise or visits.

References
BOP 1, 19, 28; CCLEO 2; CRC 37(c); ICCPR 10(1); JDL 18
PACE Codes of Practice Code C 5.4 and C 8.7
SDHP 7.5.1

Section 3: Individual rights

Detainees are informed of their legal rights on arrival and can freely exercise those rights while in custody.

Expectations
Rights relating to detention
10. Detention is appropriate, authorised and lasts no longer than is necessary.

Indicators

- In the case of immigration detainees alternative disposals are expedited.
- Appropriate grounds for detention are established.
- Alternatives to custody are considered.
- Police custody is not used as a place of safety for children under Section 65 of The Children (Northern Ireland) Order 1995.

Evidence

Custody officer
Ask:

- how they decide whether detention is appropriate;
- how they ensure the period of detention is kept to a minimum;
- whether there is regular contact with UKBA and whether this is effective in ensuring progression of their cases, with detention lasting no longer than two days; and
- whether police custody has been used as a place of safety in the last six months and what arrangements are in place to prevent this from happening again.

Documentation

- Check custody records for:
  - the reasons for initial detention;
  - the subsequent reviews of detention before charge by an inspector and extensions by a superintendent or magistrate;
  - the number of times authority for detention or an extension of detention has been given/refused.
- Check that details and management information are kept in respect of Section 65 of The Children (Northern Ireland) Order 1995 detainees.

References
BOP 2, 4, 9, 11, 37; CRC 37(b); ECHR 5; ICCPR 9; JDL 2, 17; UDHR 3, 9

11. Those under the age of 18 and vulnerable adults are not interviewed without a relative, guardian or appropriate adult present.

Indicators

- An appropriate adult (AA) scheme is in place and used.
- Relatives or guardians suitable for the role are used.

Evidence

Custody officer

Ask:

- how they make a decision about who would act as an AA; and
- what the arrangements are for providing an AA.

Documentation

Check custody records for:

- the time taken to call an AA;
- the reason for any delays; and
- the time of arrival of an AA.

Observation

Check the booking in procedures and the identification of those requiring an AA.

Detainees

Check if they may require an AA and if one was supplied.

References

BOP 1, 5(2); CRC 3, 37(c), 40; ICCPR 10(1); JDL 18

12. Detainees who have difficulty communicating are provided for.

Indicators

- Telephone and face to face translation services are provided promptly.
- Information is in a range of formats.

Evidence

Staff

Ask:

- if translation services are available, when they would be used and by whom;
- what arrangements are in place for those with learning difficulties/disabilities; and
- what other communication formats and aids are available for those who need them.

Documentation

Check the use of telephone interpretation services.

Observation
Check:
- that information is available in different languages and formats;
- what aids are in place for those who require them, for example hearing loops, etc.; and
- if written information is in easy read format.

Detainees
Check if they require any help with communication and if any was supplied.

References
BOP 1, 14, 16(3); CCLEO 2; CRC 40(2)(b)(vi); CRPD 13; DRM 4; ECHR 5(2); ICCPR 10(1); JDL 6
PACE Codes of Practice Code C 3.12

Expectations
Rights relating to PACE
13. All rights relating to PACE are adhered to

Indicators
- All detainees are able to consult with legal representatives in private for free.
- Detainees have timely legal representation.
- Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts.
- All detainees can consult a copy of PACE.
- Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit, unless in circumstances provided for under PACE.
- Detainees are not deliberately denied any services they need during the interview process and are granted a period of eight hours continuous break from interviewing in a 24-hour period.
- Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.
- Immigration detainees spend no longer in police custody than is necessary.

Evidence

Documentation
Check:
- that requests by detainees for legal advice are dealt with and managed in accordance with PACE and local arrangements for accessing solicitors;
- that immigration detainees have access to solicitors or others who are authorised by the Immigration and Asylum Act 1999 to provide free immigration advice and services;
- that detainees are able to have a private consultation with their legal advisor face to face or by phone in accordance with the arrangements described in PACE;
- that reasons are recorded if detainees decline the right to speak to a legal advisor;
- that detainees are able to have a legal advisor present when interviewed by police officers;
- custody records for evidence that PACE procedures have been followed, and for the length of time that elapses before legal advisors or advocates arrive;
- custody records to see if detainees have requested to consult PACE;
- custody records for evidence that detainees have been informed of their rights and entitlements and that any delay in being able to exercise this entitlement is authorised at inspector level or above; and
- custody records to ensure detainees are not automatically left for eight hours when they are arrested, i.e. is their case dealt with expeditiously?

Evidence

Documentation
Check:
- that requests by detainees for legal advice are dealt with and managed in accordance with PACE and local arrangements for accessing solicitors;
- that immigration detainees have access to solicitors or others who are authorised by the Immigration and Asylum Act 1999 to provide free immigration advice and services;
- that detainees are able to have a private consultation with their legal advisor face to face or by phone in accordance with the arrangements described in PACE;
- that reasons are recorded if detainees decline the right to speak to a legal advisor;
- that detainees are able to have a legal advisor present when interviewed by police officers;
- custody records for evidence that PACE procedures have been followed, and for the length of time that elapses before legal advisors or advocates arrive;
- custody records to see if detainees have requested to consult PACE;
- custody records for evidence that detainees have been informed of their rights and entitlements and that any delay in being able to exercise this entitlement is authorised at inspector level or above; and
- custody records to ensure detainees are not automatically left for eight hours when they are arrested, i.e. is their case dealt with expeditiously?

Observation
- Check:
- that information describing a detainee's legal rights is displayed in various languages and formats;
- what detainees are told about their right to a legal advisor;
- video and audio recordings, especially if detainees claim to have experienced oppressive conduct;
- that detainees are told and provided with written information about this entitlement and that their understanding is confirmed;
- that their entitlement is put into effect; and
- that this information is displayed in the custody suite.]

- Check:
- that immigration officials have served and explained to detainees, in a language they can understand, decision documents that have important consequences or that address rights of appeal;
- that custody officers communicate daily with UKBA to expedite case progression; and
- that custody staff how to access telephone advice for immigration queries and encourage immigration detainees to access this service.

Detainees
Ask:
- if they have been told about PACE and that they can consult a copy; and
- if they have been informed of their rights and entitlements and whether contact was made on their behalf.

Detainees and defence solicitors
Ask if they have concerns about the handling of detainees' individual rights.

References
BOP 1, 10–13, 16, 17, 21, 23; BPRL 1, 5–8; ECHR 5; ICCPR 10(1); JDL 18(a)
PACE Codes of Practice Code C paragraphs 3 and 5
PACE Codes of Practice Code C 3.1 (iii) and C 3(b) Detained persons – special groups
PACE Codes of Practice Code C 6 Right to legal advice
PACE Codes of Practice Code C 3.1–3.5
PACE Codes of Practice Code C 12.3
PACE Codes of Practice Code C 12 Interviews at police stations

PACE Codes of Practice Code C 2.4A

14. Effective mechanisms for ensuring continuity of evidence are in place.

Indicators

- There is a service-wide policy in place regarding the taking, submission and management of DNA and forensic samples.
- DNA and forensic samples are processed onwards from the custody suite within one week of being taken.
- There is an effective management structure in place to monitor the use of fridges and freezers for the storage of DNA and forensic samples (including the temperature of fridges/freezers).

Evidence

Custody staff

Ask:

- what the procedure is for taking DNA/forensic samples; and
- who is responsible for the upkeep of the fridges and freezers.

Documentation

Check the submission records for DNA/forensic samples.

Observation

Check:

- the quality and upkeep of fridges and freezers;
- that fridges and freezers storing exhibits and DNA do not contain any other items such as food;
- the number of samples and the dates of collection, including whether they have been submitted for processing; and
- the integrity of forensic samples.

References

CCLEO 1

15. Detainees who have been charged and refused bail appear at court promptly either in person or via video link.

Indicator
Court cut off times are reasonable.

Evidence

Custody officer
Ask what the arrangements are with the local court for transport and video link.

Documentation
Check:

- custody records for the timeliness of court appearances; and
- for the existence of video link and usage.

Defence solicitors
Ask about timings.

References
Beijing 10.2; BOP 4, 9, 11, 37; CRC 37(d); ECHR 5; ICCPR 9; JDL 17

Expectations
Rights relating to treatment
16. Detainees know how to make a complaint and are enabled to do so if they wish.

Indicators

- Detainees are told how to complain and there are systems in place to facilitate complaints.
- Complaints are taken at the earliest practicable time.
- Patterns and trends in complaints are monitored.

Evidence

Custody officers
Ask how detainees are informed about complaints procedures and if their understanding is confirmed.

Documentation
Check the records of complaints and their outcomes.

Detainees
Ask if they have been able to make complaints.

References
BOP 7, 33
PACE Codes of Practice Code C 9.2

Section 4: Healthcare

Detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

Expectations
Governance
17. Detainees are cared for by health care professionals and substance use workers who have the appropriate skills and training, in a safe, professional and caring manner that respects their decency, privacy and dignity.

Indicators
- Health care professionals and drug treatment workers are sensitive to detainees' situations and diverse needs, including language needs.
- Clinical governance arrangements include the management, training and supervision and accountability of staff.
- Patients are treated by health care staff who receive ongoing training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular health care needs of detainees in police custody.
- Clinical examinations are conducted confidentially unless risk assessment suggests otherwise. Treatment rooms provide conditions that maintain decency, privacy and dignity. Infection control facilities are implemented. There is at least one room that is appropriate for taking forensic samples, and it is clean.
- All equipment (including the resuscitation and first aid kits) is ready for use and regularly checked and maintained, and all staff (health care and custody staff) understand how to access and use it effectively.

Evidence

Staff/observation
Ask/observe:
- whether detainees can see a health professional of the gender of their choice on request and if there are arrangements for a chaperone to be present if required;
- what arrangements are in place for detainees who cannot speak English, and check the use of interpreters or telephone translation services;
- whether the clinical notes or notes made by arrest referral workers provide evidence of involvement of family/carers/caseworkers/advocates;
- to whom staff (FMOs, nurses, other health care professionals) report in the police;
- where their line manager is located;
- which clinical governance arrangements are explicit in the service level agreement/contract and whether they include specifics about the need for staff to receive ongoing training and support to maintain professional registration;
- who is responsible for monitoring the contracts – police and/or contractor;
- whether doctors are contracted solely to FMO duties when on duty and whether their hours of work are appropriate;
- where professional registration details are held and the systems for verifying registration;
- what the arrangements are for clinical supervision;
- what training, supervision/appraisal and support health care staff receive, and whether they feel they have the skills, knowledge and competencies to meet the health care needs of all detainees;
- the condition of treatment rooms, infection control measures and procedures, whether they provide decency and privacy, and if they are solely for the use of health professionals;

- whether resuscitation equipment is readily available, including equipment for the maintenance of an airway, oxygen and defibrillator; and
- whether all staff know the location of resuscitation equipment, how to use it and if they receive annual resuscitation training.

Documents
Check:
- the contract specification/service level agreement;
- the clinical governance policy;
- staff rotas;
- training/CPD registers, appraisal documentation and training/CPD plans relevant to the service being delivered and information on who each FMOs 'responsible officer' is;
- the infection prevention and control policy; regular audits; cleaning schedules; and
- documented checks of resuscitation equipment.

Detainees
Speak to detainees about their treatment and whether their diverse needs are respected.

Observe
- Interactions between detainees and health care staff.
- The time given for each consultation.
- Consultations (with the detainee's permission).

References
BOP 1, 24; CCLEO 2, 6; ICCPR 10(1); ICESCR 12(1); PME 1; PPPMI 1, 20; RTWP 62
PACE Codes of Practice Code Note 9A and C 9.5–9.14
SDHP 7.2.1, 7.2.4, 9.3, 10.2.5, 10.2.8, 12.6.5 and Appendix 11, 12 and 14
HSfW 1, 2, 5, 6, 8, 10, 14, 19, 22, 24, 27, 28
http://www.resus.org.uk/siteindx.htm

Expectations
Patient care
18. Detainees are asked if they wish to see a health care professional and are able to request to see one at any time, for both physical and mental health needs, and are treated appropriately.

Indicators
- Each detainee seen by health care staff has a clinical record containing an up to date assessment and any care plan conforms to professional guidance from the regulatory bodies. The ethnicity of the detainee is also recorded.
- Any contact with a doctor or other health care professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.
- Treatments are appropriate to the clinical needs of the detainee.

Evidence

Staff

Ask:

- what the procedure is for calling a health professional;
- what the arrangements are for recording health interventions and transferring information about medication to the custody record;
- how the consent of detainees is obtained and how the results of clinical examinations are shared with detainees and their legal representatives;
- what the arrangements are for out of hours cover; and
- how staff check mental capacity.

Documentation

- Check:
  - that a sample of clinical records from the last six months includes the detainee's signature to determine consent for the sharing of information, a record of the detainee's ethnicity, the problems experienced, the diagnosis, treatment, care plan and referral letters;
  - that records are kept confidentially, in line with Caldicott guidelines, and in compliance with professional guidance;
  - record of calls and response monitoring;
  - complaints concerning health care provision.
- Cross-reference clinical records with custody records.

Detainees

Ask whether their health needs have been met.

Defence solicitors

Ask:

- whether the detainees they represent have made any complaints concerning health care provision;
- if the results of a detainee's clinical examination are shared; and
- whether their consent is sought in advance.

Observation

Observe whether custody staff offer detainees the opportunity to see a health services professional.

References

BOP 24, 26; CCLEO 6; ICESCR 12(1); PME 1; PPPMI 1, 20
PACE Codes of Practice Code C 9.15–9.17
HSfW 2, 3, 7, 8, 25, 26
SDHP 7.2

19. Detainees receive prescribed medication if needed.

Indicators

- All medications on site are stored safely, securely, and disposed of safely if not consumed.
- There is safe pharmaceutical stock management and use.
- Detainees are prescribed medication to meet any clinical signs, symptoms or conditions.
- Detainees receive medication to provide relief for drug and alcohol withdrawal symptoms if clinically indicated.
- Prescribed medication is received at the designated times.

Evidence

Staff

Ask/observe:

- what the procedures are for the prescribing and administration of medications;
- how liaison between health care staff, drug/alcohol referral workers or community drugs workers functions;
- about the policies and procedures in place relevant to the administration of medications;
- how prescribed medications are obtained, who is able to administer the medications, and what audit trail there is for the request, receipt, prescription, administration and disposal of medications;
- about the arrangements for the access to, storage, dispensing and disposal of pharmaceuticals, and whether they are appropriately labelled;
- how stock levels of medications are decided, reviewed, recorded and monitored;
- if health professionals carry medications and, if so, whether they are in a secure container at all times
- whether health care staff have 24-hour access to the support of a pharmacist; and
- if medications that are brought in by the detainee are returned to them when they are released.

Detainees

Ask about access to prescribed medication and drug/alcohol withdrawal relief.

References

BOP 24, 26; CCLEO 6; ICESCR 12(1)
PACE Codes of Practice Code C 9.9–9.12 and 9.15–9.17
SDHP 7.2.4
HSfW 7

Expectations
Substance use
20. Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred to community drugs/alcohol teams or prison drugs workers as necessary.

Indicators
A service is provided for all drug and alcohol users.

Evidence

Staff
Ask:
- what arrangements are in place to provide services and liaison between health care staff, drug/alcohol referral workers and community drugs workers; and
- whether the services include children.

Observation
Are detainees who are to be released into the community offered clean needles by drug referral workers?

Detainees
Ask whether they have been offered the services of a drug or alcohol arrest referral worker.

References
BOP 24; CCLEO 6; ICESCR 12(1); RTWP 62
SDHP – custody process map

Expectations
Mental health
21. A liaison and/or diversion scheme enables detainees with mental health problems to be identified and diverted into appropriate mental health services, or referred on to prison health services.

Indicators
- The scheme exists and there are arrangements for referral.
- Staff have an awareness of mental health issues, their identification and dealing with them.

Evidence

Staff
Ask what works well and what the barriers are to effectiveness.

Observation
Check:
- the published rota for mental health staff cover and on call arrangements;
- that there are information sharing protocols in place to ensure that there is efficient sharing of relevant health and social care information; and
- the monitoring of response times and outcomes.

References
BOP 24; CCLEO 6; CRPD 14; ICESCR 12(1); PPPMI 1, 9, 20
SDHP 2.4.5

22. Police custody is not used as a place of safety for Section 130 of The Mental Health (Northern Ireland) Order[37].

Indicators

- There are local arrangements in place with the relevant mental health trust.
- There are arrangements in place with local authorities for assessments under the Mental Health Order.
- Details and management information are kept in respect of Section 130 detainees.
- Standardised data collection on the use of Section 130 is routinely reviewed.
- The police are represented on liaison groups or a local multi-agency Section 130 group, which monitors the use of Section 130, identifies any problems with interagency working and develops solutions to address problems.

Evidence

Observation

Check:

- local protocols;
- the nature of the local arrangements – look for exclusion clauses that might result in police custody being used as a place of safety;
- the timescales for police to contact an approved mental health practitioner for an initial assessment to begin, and that timescales are met;
- the arrangements made for medical attendance in Section 130 cases;
- any issues that have risen over transfer between the place of safety and the timescales recorded; and
- the Section 130 suite at local health service facilities.

Detainees

Ask about how they were conveyed to the place of safety (ambulance/police transport) and the information given about their rights.

References

ICCPR 9; ICESCR 12(1); PPPMI 9, 20
PACE Codes of Practice Code C Annex E
SDHP 2.4.5, 3.4

[37] Section 130 of The Mental Health (Northern Ireland) Order provides that if a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.

Annex: list of abbreviations

International human rights instruments

Legally binding

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

Normative

Beijing	United Nations Standard Minimum Rules for the Administration of Juvenile Justice
BOP	Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment
BPRL	Basic Principles on the Role of Lawyers
BPUF	Basic Principles on the Use of Force and Firearms by Law Enforcement Officials
CCLEO	Code of Conduct for Law Enforcement Officials
DEDRB	Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief
DHRIN	Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live
DRM	Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities
JDL	United Nations Rules for the Protection of Juveniles Deprived of their Liberty
PME	Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
POP	United Nations Principles for Older Persons
PPPMI	Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
RTWP	United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)
UDHR	Universal Declaration of Human Rights

Regional human rights instruments

Legally binding

ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms

Additional acronyms

PACE	Police and Criminal Evidence Act 1984 / Police and Criminal Evidence (Northern Ireland) Order 1989 Code C sets out the requirements for the detention, treatment and questioning of suspects in police custody other than in terrorism cases to which Code H applies.
SDHP	Safer Detention and Handling of Persons in Police Custody (2006 and 2012 revision)

References

Equality Act 2010
Mental Capacity Act 2005
Mental Health Act 1983, Code of Practice (updated 2008) Ch. 10
Standards for Better Health (2004)
UK Border Agency (2011), *Enforcement Instructions and Guidance: Detention and Temporary Release*, Ch. 55

Appendix 2: Terms of reference

An inspection of police custody in Northern Ireland

Introduction
Criminal Justice Inspection Northern Ireland (CJI) proposes to undertake a joint inspection, with the Regulation and Quality Improvement Authority (RQIA), of the detention of persons in police custody in Northern Ireland.

The United Nations General Assembly adopted OPCAT (the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment) in 2002 with the aim to create a system of regular inspections of places of detention throughout the world, and provide a preventative measure to address potential torture or inhuman treatment. The United Kingdom signed up to OPCAT in 2003. The United Kingdom Government subsequently designated a number of bodies across England, Wales, Scotland and Northern Ireland as members of the 'National Preventative Mechanism' (NPM). These organisations are required to conduct regular visits to places of detention in order to prevent acts of torture and cruel, inhuman and degrading treatment or punishment. CJI and RQIA are both designated bodies and therefore this inspection serves to assist in discharging responsibilities as part of the NPM.

Context
This is the second full inspection of police custody in Northern Ireland, which will consider the strategy, governance and delivery of custody by the PSNI. CJI and RQIA published the first full inspection in 2009 and a subsequent follow-up review in 2012. These inspections identified issues which still required resolution including the governance and management of the custody suites and the approach to healthcare in custody. As a result CJI decided to undertake a further full inspection. Since the initial inspection and follow-up review PSNI have undertaken a number of internal reviews concerning police custody, particularly regarding the number of custody suites required, standards of the suites themselves, the provision of healthcare to detainees and the ability of the PSNI to access services from other partners for the detainees.

From 1 April 2015 the PSNI intends to alter its district policing structures in order to align itself with new Local Government Councils in Northern Ireland. These changes will impact on the management structure of the custody suites and this forms part of a change programme for custody which the PSNI has embarked upon. This proposed inspection will therefore be timely in order to assess progress to date and identify any issues or risks for the programme as it proceeds.

Aims of the inspection

The broad aims of the inspection are to:

- assess the PSNI's strategy and governance of police custody;
- assess the treatment of detainees and conditions in which they are held;
- assess the extent to which the individual rights of detainees are upheld; and
- assess the provision of healthcare to detainees.

Methodology

The inspection will focus on assessing the performance of the PSNI against the current (version 2, 2012) 'expectations' for police custody. The expectations were developed by Her Majesty's Inspectorates of Prisons (HMIP) and Constabulary (HMIC) in consultation with police and stakeholder organisations. The PSNI was assessed against these expectations in the 2009 inspection and these enable CJI and RQIA to inspect the PSNI against a common standard with police forces in England and Wales.

The expectations are based upon the principles of OPCAT as well as international human rights instruments, legal requirements as set out in the Police and Criminal Evidence Act (1984) / Police and Criminal Evidence (Northern Ireland) Order (1989) and the guidance contained in the Safer Detention and Handling of Persons in Police Custody (2006 and 2012 revision).

The expectations have been tailored for use in Northern Ireland (for example to reflect local legislation).

This inspection will focus on the use of custody suites which are designated to be used for the purpose of detaining arrested persons under Section 36 of the Police and Criminal Evidence (Northern Ireland) Order 1989.

Design and planning

Documentation such as policies, procedures and service orders provided by the PSNI will be reviewed prior to the fieldwork. In addition material which sets out proposals for the PSNI custody change programme will be reviewed.

Delivery

Stakeholder consultation

Stakeholders from external partner agencies and voluntary and community organisations will be consulted as part of the fieldwork. This will include:

- Children’s Commissioner for Northern Ireland;
- Committee on the Administration for Justice;
- Defence solicitors;
- Department of Justice;
- Equality Commission;
- Health and Social Care Board/Public Health Agency mental health lead;
- Health and Social Care Trusts Unscheduled Care Emergency Department lead;
- Department of Health;

- Her Majesty's Revenue and Customs;
- Human Rights Commission for Northern Ireland;
- Judiciary;
- Juvenile Justice Centre;
- Office of the Police Ombudsman for Northern Ireland; and
- Prison Service Governors (Maghaberry/Hydebank Wood).

In addition the view of adult detainees will be sought via questionnaire survey/interview both in the custody suites themselves and in the remand wings of Maghaberry, Hydebank Young Offenders Centre, Hydebank Wood Women's Prison. The views of children recently remanded to the Juvenile Justice Centre will also be sought.

Development of fieldwork plan
CJI will liaise with PSNI Inspection Liaison to arrange a series of meetings and focus groups with relevant officers and police staff in the PSNI, as well as partners who provide services to detainees within the custody suites. In addition CJI and RQIA will plan a series of unannounced visits to custody suites during the fieldwork period in April 2015.

Feedback to agency
On conclusion of the fieldwork the evidence will be collated, triangulated and analysed and emerging recommendations will be developed. CJI and RQIA will then present the findings to the PSNI.

Drafting of report
Following completion of the fieldwork and analysis of data, a draft report will be shared with the inspected bodies for factual accuracy check. The Chief Inspector will invite the inspected bodies to complete an action plan within 6 weeks to address the recommendations and if the plan has been agreed and is available it will be published alongside the final inspection report. The inspection report will be shared, under embargo, in advance of the publication date with the inspected bodies.

Publication and closure
A report will be sent to the Minister of Justice for permission to publish. When permission is received the report will be finalised for publication. A press release will be drafted and shared with the PSNI prior to publication and release. A publication date will be agreed and the report will be issued.

Brendan McGuigan
Chief Inspector of Criminal Justice in Northern Ireland

Appendix 3: Detainee questionnaire survey

Police custody survey

Section 1: About you

Q1 **Name (optional):**

____

Q2 **Which police station were you last held at?**

____

Q3 **How old are you?**

- *16 years or younger* .... P
- *17-21 years* .... P
- *22-29 years* .... P
- *30-39 years* .... P
- *40-49 years* .... P
- *50-59 years* .... P
- *60 years or older* .... P

Q4 **Are you:**

- *Male* .... P
- *Female* .... P
- *Transgender/Transsexual* .... P

Q5 **What is your ethnic origin?**

- *White* .... P
- *Chinese* .... P
- *Irish Traveller* .... P
- *Indian* .... P
- *Pakistani* .... P
- *Bangladeshi* .... P
- *Black Caribbean* .... P
- *Black African* .... P
- *Black Other* .... P
- *Mixed Ethic Group* .... P

  Please Specify:

  ____
- *Other ethnic group* .... P

  Please Specify:

  ____

Q6 **Are you a foreign national (i.e. you do not hold a British or Irish passport, or you are not eligible for one)?**

- *Yes* .... P
- *No* .... P

Q7 **What, if any, is your religion?**

None .... P
Roman Catholic .... P
Presbyterian Church in Ireland .... P
Church of Ireland .... P
Methodist .... P
Other Christian .... P
Buddhist .... P
Hindu .... P
Jewish .... P
Muslim .... P
Sikh .... P
Any other religion, please specify ____________

Q8 **How would you describe your sexual orientation?**

Straight/heterosexual .... P
Gay/lesbian/homosexual .... P
Bisexual .... P
Other (please specify): ____________

Q9 **Do you consider yourself to have a disability?**

Yes .... P
No .... P

Q10 **Have you ever been held in police custody before?**

Yes .... P
No .... P

Section 2: Your experience of the police custody suite

Q11 **How long were you held at the police station?**

Less than 24 hours .... P
More than 24 hours, but less than 48 hours (2 days) .... P
More than 48 hours (2 days), but less than 72 hours (3 days) .... P
72 hours (3 days) or more .... P

Q12 **Were you told your rights when you first arrived there?**

Yes .... P
No .... P
Don't know/Can't remember .... P

Q13 **Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**

Yes .... P
No .... P
I don't know what this is/I don't remember .... P

Q14 **If your clothes were taken away, what were you offered instead?**

My clothes were not taken .... P
I was offered a tracksuit to wear .... P

I was offered an evidence/ paper suit to wear .... P
I was **only** *offered a blanket* .... P
Nothing .... P

Q15 Could you use a toilet when you needed to?
Yes .... P
No .... P
Don't Know .... P

Q16 If you used the toilet there, was toilet paper provided?
Yes .... P
No .... P

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	P	P	P
Ventilation/air quality	P	P	P
Temperature	P	P	P
Lighting	P	P	P

Q18 Was there any graffiti in your cell when you arrived?
Yes .... P
No .... P

Q19 Did staff explain to you the correct use of the cell bell?
Yes .... P
No .... P

Q20 Were you held overnight?
Yes .... P
No .... P

Q21 If you were held overnight, which items of bedding were you given? (Please tick all that apply)
Not held overnight .... P
Pillow .... P
Blanket .... P
Nothing .... P

Q22 If you were given items of bedding, were these clean?
Not held overnight / Did not get any bedding .... P
Yes .... P
No .... P

Q23 Were you offered a shower at the police station?
Yes .... P
No .... P

Q24 Were you offered any period of outside exercise while there?
Yes .... P
No .... P

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	P	P
Drink?	P	P

Q26 **What was the food/drink like in the police custody suite?**

Very good	*Good*	*Neither*	*Bad*	*Very Bad*	*N/A*
P	P	P	P	P	P

Q27 **Was the food/drink you received suitable for your dietary requirements?**

I did not have any food or drink .... P
Yes .... P
No .... P

Q28 **If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply)**

I do not smoke .... P
I was allowed to smoke .... P
I was offered a nicotine substitute .... P
I was not offered anything to cope with not smoking .... P

Q29 **Were you offered anything to read?**

Yes .... P
No .... P

Q30 **Was someone informed of your arrest?**

Yes .... P
No .... P
I don't know .... P
I didn't want to inform anyone .... P

Q31 **Were you offered a free telephone call?**

Yes .... P
No .... P

Q32 **If you were denied a free phone call, was a reason for this offered?**

My telephone call was not denied .... P
Yes .... P
No .... P

Q33 **Did you have any concerns about the following, while you were in police custody?**

	Yes	*No*
Who was taking care of your children	P	P
Contacting your partner, relative or friend	P	P
Contacting your employer	P	P
Where you were going once released	P	P

Q34 **Were you offered free legal advice?**

Yes .... P

No .... P

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice .... P
Yes .... P
No .... P

Q36 Were you interviewed by police about your case?

Yes .... P
No .... P If No, go to Q41

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor / Was not interviewed .... P
Yes .... P
No .... P

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult / Was not interviewed .... P
Yes .... P
No .... P

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter / Was not interviewed .... P
Yes .... P
No .... P

Q40 Do you have any other comments about your time in police custody?

____
____
____
____
____
____

Section 3: Safety

Q41 Did you feel safe there?

Yes .... P
No .... P

Q42 Did a member of staff victimise (insult or assaulted) you there?

Yes .... P
No .... P

Q43 If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised .... P
Insulting remarks (about you, your family or friends) .... P
Physical abuse (being hit, kicked or assaulted) .... P
Sexual abuse .... P
Your race or ethnic origin .... P
Drugs .... P
Because of your crime .... P
Because of your sexuality .... P
Because you have a disability .... P
Because of your religion/religious beliefs .... P
Because you are from a different part of the country than others .... P

Please describe:

Q44 Were your handcuffs removed on arrival at the police station?

Yes .... P
No .... P
I wasn't handcuffed .... P

Q45 Were you restrained whilst in the police custody suite?

Yes .... P
No .... P

Q46 Were you injured while in police custody, in a way that was not your fault?

Yes .... P
No .... P

Q47 Were you told how to make a complaint about your treatment if you needed to?

Yes .... P
No .... P

Q48 How were you treated by staff in the police custody suite?

Very well	*Well*	*Neither*	*Badly*	*Very Badly*	*Don't remember*
P	P	P	P	P	P

Q49 Do you have any other comments about safety in the police custody suite?

Section 4: Healthcare

Q50 Did someone explain your entitlements to see a doctor, if you needed to?

Yes .... P
No .... P
Don't know .... P

Q51 Were you seen by a doctor during your time there?

I didn't need to see a doctor .... P
Yes .... P
No .... P

Q52 Were you able to see a doctor of your own gender?

Yes .... P
No .... P
Don't know .... P

Q53 Did you need to take any prescribed medication when you were in police custody?

Yes .... P
No .... P

Q54 Were you able to continue taking your prescribed medication while there?

Not taking medication .... P
Yes .... P
No .... P

Q55 Did you have any drug or alcohol problems?

Yes .... P
No .... P

Q56 Did you see, or were you offered the chance to see a drug or alcohol support worker?

I didn't have any drug/alcohol problems .... P
Yes .... P
No .... P

Q57 Were you offered relief or medication for your immediate withdrawal symptoms?

I didn't have any drug/alcohol problems .... P
Yes .... P
No .... P

Q58 Please rate the quality of your healthcare while in police custody:

I was not seen by healthcare	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
P	P	P	P	P	P

Q59 **Did you have any specific <u>physical</u> healthcare needs?**

Yes .... P
No .... P

Q60 **Did you have any specific <u>mental</u> healthcare needs?**

Yes .... P
No .... P

Q61 **If you had any mental healthcare needs, were you seen by a mental health nurse / psychiatrist?**

I didn't have any mental healthcare needs .... P
Yes .... P
No .... P

Q62 **Do you have any comments about healthcare in the police custody suite?**

____
____
____
____
____
____
____

Q63 **Do you have any other comments about your time in the police custody suite?**

____
____
____
____
____
____
____

<u>Thank you for your time.</u>

Appendix 4: Detainee questionnaire survey results

Missing data have been excluded for each question. Due to rounding not all totals add to exactly 100%. Where questions differ from those asked in 2009 the box has been greyed out. General information relates only to detainees surveyed (not to actual detainees held by PSNI).

		2015	2009
Number of completed questionnaires:		**55**	**48**
SECTION 1: General information			
2	Station held at:		
	Antrim	15%	23%
	Bangor	7%	10%
	Coleraine	9%	2%
	Dungannon	2%	2%
	Enniskillen	5%	-
	Grosvenor Road	2%	8%
	Lurgan	7%	-
	Lurgan and Dungannon	-	2%
	Musgrave Street	35%	10%
	Omagh	4%	-
	Strabane	-	2%
	Strand Road	15%	10%
3	Are you under 21 years of age?	51%	52%
4	Are you transgender/transsexual?	0	0
5	Are you from a minority ethnic group? (Inc all those who did not tick white British, white Irish or white other categories)	2%	4%
6	Are you a foreign national?	7%	6%
7	What, if any, is your religion:		
	None	9%	8%
	Presbyterian/Church of Ireland/Methodist/other Christian	38%	42%
	Roman Catholic	53%	48%
	Non-Christian (Buddhist, Hindu, Jewish, Muslim, Skih)	0	0
8	Are you homosexual/gay or bisexual?	0	2%
9	Do you consider yourself to have a disability?	35%	23%
10	Have you been in police custody before?	71%	75%
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for more than 24 hours?	43%	69%
12	Were you told of your rights when you first arrived?	76%	77%
13	Were you told about PACE?	56%	50%
14	Were you given a tracksuit to wear?	58%	10%
15	Could you use the toilet when you needed to?	96%	83%
16	If you used the toilet, was toilet paper provided?	80%	84%
17	Would you rate the condition of your cell as 'good' for:		
17a	Cleanliness?	60%	40%
17b	Ventilation/air quality?	47%	25%
17c	Temperature?	45%	19%
17d	Lighting?	58%	35%
18	Was there any graffiti in your cell when you arrived?	11%	50%
19	Did staff explain the correct use of the cell bell?	62%	38%
20	Were you held overnight?	96%	90%
For those held overnight:			
21	Were you given any items of bedding?	98%	84%

		2015	2009
For those who were held overnight and were given items of bedding:			
22	Were these clean?	89%	-
23	Were you offered a shower?	20%	33%
	For those held over 24 hours	30%	38%
24	Were you offered a period of outdoor exercise?	5%	6%
	For those held over 24 hours	13%	9%
25a	Were you offered anything to eat?	93%	83%
25b	Were you offered anything to drink?	98%	85%
26	Was the offer of food and drink you received 'good'/'very good'?	21%	-
27	Was the food and drink suitable for your dietary requirements?	88%	56%
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	24%	20%
29	Were you offered anything to read?	16%	13%
30	Was someone informed of your arrest	78%	82%
31	Were you offered a free telephone call?	69%	54%
If you were denied a free telephone call:			
32	Was a reason given?	17%	16%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	11%	13%
33b	Contacting your partner, relative or friend?	33%	35%
33c	Contacting your employer?	4%	4%
33d	Where you were going once released?	36%	19%
34	Were you offered free legal advice?	89%	-
For those who were offered free legal advise:			
35	Did you accept the offer of free legal advice?	65%	-
36	Were you interviewed by police about your case?	69%	90%
For those who were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	97%	74%
38	Was an appropriate adult present when you were interviewed?	100%	52%
39	Was an interpreter present when you were interviewed?	100%	33%
SECTION 3: Safety			
41	Did you feel safe?	85%	56%
42	Were you victimised by a member of staff?	9%	33%
43	If you felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	40%	50%
43b	Physical abuse (being hit, kicked or assaulted)	100%	44%
43c	Sexual abuse	0%	6%
43d	Your race or ethnic origin	0%	6%
43e	Drugs	0%	19%
43f	Because of your crime	0%	63%
43g	Because of your sexuality	0%	0%
43h	Because of you have a disability	0%	0%
43i	Because of your religion/religious beliefs	0%	13%
43j	Because you are from a different part of the country than others	0%	6%
44	Were your handcuffs removed on arrival at the police station?	90%	-
45	Were you restrained while in the police custody suite?	15%	40%
46	Were you injured whilst in police custody, in a way that was not your fault?	11%	28%
47	Were you told how to make a complaint about your treatment?	35%	30%
48	Were you treated well/very well by staff in the police custody suite?	72%	-
SECTION 4: Health Care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	94%	38%
51	Were you seen by a doctor during your time in police custody?	94%	81%
52	Were you able to see a doctor of your own gender?	78%	43%
53	Did you need to take any prescribed medication when you were in police custody?	56%	38%
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	67%	52%

55	Did you have any drug or alcohol problems?	31%	55%
For those who had drug or alcohol problems:			
56	Did you see, or were you offered the chance to see a drug or alcohol support worker?	13%	21%
57	Were you offered relief or medication for your immediate withdrawal symptoms?	27%	21%
For those who were seen by health care:			
58	Would you rate the quality as 'good'/'very good'?	65%	41%
59	Did you have any specific physical health care needs?	31%	30%
60	Did you have any specific mental health care needs?	37%	38%

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