



POLICE CUSTODY

THE DETENTION OF PERSONS
IN POLICE CUSTODY IN
NORTHERN IRELAND

SEPTEMBER 2020



The Regulation and
Quality Improvement
Authority

POLICE CUSTODY

THE DETENTION OF PERSONS IN POLICE CUSTODY IN NORTHERN IRELAND

SEPTEMBER 2020

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LIST OF ABBREVIATIONS

AED	Automated External Defibrillator
APP	Authorised Professional Practice
BHSCT	Belfast Health and Social Care Trust
CCTV	Closed-Circuit Television
CDO	Custody Detention Officer
CJI	Criminal Justice Inspection Northern Ireland
CS	2-chlorobenzalmalononitrile a cyanocarbon
CSE	Child Sexual Exploitation
DNA	Deoxyribonucleic acid
DoH	Department of Health
DoJ	Department of Justice
FMO	Forensic Medical Officer
GP	General Practitioner
HMICS	Her Majesty's Inspectorate of Constabulary in Scotland
HMICFRS/HMIC	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (formerly Her Majesty's Inspectorate of Constabulary) (in England and Wales)
HMIP	Her Majesty's Inspectorate of Prisons (in England and Wales)
HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
ICV(s)	Independent Custody Visitor(s)
IT	Information Technology
MHO	Mental Health Order
NIAAS	Northern Ireland Appropriate Adult Scheme
NicheRMS	Records Management System developed by Niche Technology Inc. used by PSNI
NIECR	Northern Ireland Electronic Care Record
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

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INSPECTOR'S
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PHA	Public Health Agency
PPE	Personal Protective Equipment
PPS	Public Prosecution Service for Northern Ireland
PSNI	Police Service of Northern Ireland
RO	Responsible Officer
RQIA	Regulation and Quality Improvement Authority
UK	United Kingdom
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
Woodlands JJC	Woodlands Juvenile Justice Centre

CHIEF INSPECTOR'S FOREWORD

Every day the Police Service of Northern Ireland deal with detainees, all have individual needs and many have a complex range of mental health, alcohol and substance misuse and aggression issues. Some are children and young people, who may have a history of life in care, behavioural difficulties and educational needs or are vulnerable adults which means that a police custody suite is not the most appropriate place for them.

Effectively engaging with detainees to make sure they have any immediate physical and mental health needs met, they are kept safe and legal requirements complied with while in custody presents a constantly challenging working environment for Police Officers, Custody Detention Officers and health professionals. Regardless of whether detainees have been in police custody many times before or this is their first time, they each have individual needs that need to be assessed and risks managed.

This report follows the periodic inspection of police custody facilities and arrangements in Northern Ireland. These inspections are carried out by the Regulation and Quality Improvement Authority and Criminal Justice Inspection Northern Ireland partners and demonstrate our obligations as members of the National Preventive Mechanism to protect people in custody from ill treatment and abuse.

Effective partnerships involving the range of service providers are vital and can impact on outcomes for detainees. The pathfinder partnership of on-site support from nurse professionals in Musgrave custody suite are effective initiatives and models of health care provision that merit sustaining and further development across the entire police custody suite estate.

The Covid-19 pandemic has accelerated the use of video technology in police custody suites for first appearances in court and has provided evidence of what can be achieved to inform more permanent legislative reform. The benefits of this should not be lost in the restoration of more court hearings, particularly for those most vulnerable detainees.

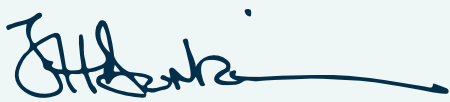
This report makes a number of strategic and operational recommendations and areas for improvement that will build on existing effective partnerships and deliver better police custody services when implemented.

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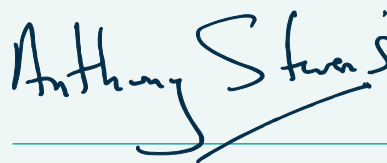
This inspection was led by Rachel Lindsay and David MacAnulty of Criminal Justice Inspection Northern Ireland in partnership with a team of Inspectors from the Regulation and Quality Improvement Authority, led by Emer Hopkins. I am grateful to all those involved in the inspection, particularly those detainees who spoke to Inspectors about their experience in police custody.


Jacqui Durkin

Chief Inspector of Criminal Justice
in Northern Ireland

September 2020

**Criminal Justice Inspection
Northern Ireland**
a better justice system for all



Dr A B Stevens OBE

Interim Chief Executive
Regulation and Quality Improvement
Authority

September 2020

 The **Regulation and
Quality Improvement
Authority**

EXECUTIVE SUMMARY

Introduction

When any person is arrested the police have a duty to ensure that subsequent detention complies with international standards as “*Detention by the police is the moment when detainees are most at risk of ill-treatment or of suffering other types of abuse*”¹. The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is an international human rights treaty designed to strengthen protection for people who are detained. Inspections on the efficiency, effectiveness and treatment of detained persons in the custody of the Police Service of Northern Ireland are conducted by Criminal Justice Inspection Northern Ireland (CJI) and the Regulation Quality and Improvement Authority. This report is the result of the third such inspection, with fieldwork conducted in 2019 to assess the Police Service of Northern Ireland’s delivery in this area against the *Expectations for police custody*².

Data provided by the Police Service of Northern Ireland indicated that there had been 26,160 detainees held in custody during 2018-19. Data from the Police Service of Northern Ireland and the custody record analysis conducted by CJI highlighted the complex risks and needs

of detainees in police custody in terms of vulnerabilities, intoxication and mental health.

Leadership, accountability and partnerships

An Assistant Chief Constable had responsibility for custody and there was a dedicated team in District Policing Command, led by a Chief Superintendent, which provided strategic and operational governance. The custody policy reflected College of Policing and other United Kingdom guidance and was supported by a range of documents on the Police Service of Northern Ireland intranet site, available to custody staff.

Training was provided by the Police Service of Northern Ireland for Custody Sergeants, Custody Detention Officers and Constables working in custody and training had a focus on vulnerability. Police Service of Northern Ireland policies on child protection and adult safeguarding reflected the Department of Health and Department of Justice policies, although both focused more on their needs as victims rather than when they were suspected of an offence. Diversionary approaches, particularly for children, were a focus for the Police Service of Northern Ireland. However there were difficulties

1 Association for the Prevention of Torture, *Police custody: Risks and safeguards*, APT website, online at: www.apr.ch/en/police-custody-risks-and-safeguards/.

2 The *Expectations for police custody* were developed by Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (formerly Her Majesty’s Inspectorate of Constabulary) and Her Majesty’s Inspectorate of Prisons for use in England and Wales as the standards against which delivery of police custody by police forces was assessed. These have been adapted for use in Northern Ireland. See Chapter 1 and Appendix 1 for more details.

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in applying diversionary approaches to ‘Looked After’ children³, who resided in children’s homes. The development of a Bail Act, to clarify the position in relation to children brought into custody, was still outstanding and support to secure legislative reform to address the issue of bail for children and young people is still required. Strategic discussions to address the difficult issue of ‘Looked After’ children between the Police Service of Northern Ireland and the Health and Social Care Board had stalled but Inspectors recommend these be re-established. Police custody was not often used as a ‘place of safety’ for those detained under mental health powers but this provision remained in the new Mental Capacity Act (Northern Ireland) 2016⁴.

Performance management data was routinely collected and analysed and the Police Service of Northern Ireland had developed a quality assurance programme to ensure consistency of decision making and recording across the custody suites. Inspectors acknowledge the benefits of this work. Information in relation to adverse incidents in custody was shared and escalated as appropriate.

The custody record required the collection of data for equality monitoring purposes, although community background and sexual orientation were important categories which were not included.

CJI recommend the Police Service of Northern Ireland collect data on all the Section 75⁵ categories in this monitoring. The Northern Ireland Policing Board’s Independent Custody Visiting Scheme were regularly present in the suites and had a constructive working relationship with custody staff. Partnerships with other agencies who were users of the custody suites or provided services tended to be issue specific, but partners also reported positive engagement with custody staff.

Pre-custody: first point of contact

A variety of diversionary options for both children and adults were available to operational officers but their use was sometimes frustrated by the detainee being intoxicated or violent, with other agencies declining to accept them into their care, resulting in them having to be detained by the police. Police systems enabled people with vulnerabilities or who presented risks to themselves or others to be identified. The Multi-Agency Triage Team was a commendable joint initiative by health and justice professionals to keep people in mental health crisis out of custody. The processes on arrival at custody enabled Custody Sergeants to identify and make decisions about how to deal with risks and needs as soon as the detainee arrived in custody, even sometimes before they arrived at the booking in desk.

3 The Department of Health website states: A child is looked after by an authority if he or she is in their care or if he or she is provided with accommodation for a continuous period of more than 24 hours by the authority in the exercise of its social services function. Children are taken into care for a variety of reasons, the most common being to protect a child from abuse or neglect. In other cases their parents could be absent or may be unable to cope due to disability or illness. See www.health-ni.gov.uk/articles/looked-after-children.

4 See www.legislation.gov.uk/nia/2016/18/section/160.

5 Section 75 of the Northern Ireland Act 1998 places a statutory obligation on public authorities to carry out their functions with due regard to the need to promote equality of opportunity and good relations in respect of religious belief, political opinion, gender, race, disability, age, marital status, dependants and sexual orientation.

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

Inspectors were told by most detainees that they were treated well in custody and this was reinforced by observations during several suite visits. Many custody staff were clearly very skilled and experienced in dealing with distressed, intoxicated and challenging people and circumstances.

Detainees were advised of their rights during the booking in process and were able to avail of a written copy of these. The Police Service of Northern Ireland was able to respond to the needs of detainees from different genders, religions, with differing communication needs and skill was exercised in addressing these different needs. The risk assessment process, guided by the custody record, was detailed and Custody Officers were skilled in eliciting the appropriate information. Drugs were cited as particularly challenging to risk assess by custody staff and they would welcome more training in this area. There were inconsistencies in the application of College of Policing guidance on levels of observation in the care plan. CJI recommend that the Police Service of Northern Ireland take steps to address this and improve the recording of decision making.

There were no issues identified around the length of time detainees spent in custody with specialist teams advancing cases to assist with the custody process. Only 10 detainees in the 100 custody records sampled were held in custody for more than 24 hours. Reviews of detention were generally conducted in accordance with the provisions of the Police and Criminal Evidence (Northern Ireland) Order 1989. However most were conducted while the

detainee was sleeping, which requires further examination by the Police Service of Northern Ireland.

The legal rights of detainees were being met appropriately and relationships with legal representatives were professional and positive. The custody record analysis showed a greater use of police bail for children than for adults. Bail management was reported to have been improved with specialist teams having oversight of bail returners. Woodlands Juvenile Justice Centre was used for some children for Police and Criminal Evidence (Northern Ireland) Order 1989 remand, depending on accessibility, but analysis showed that 'Looked After' children spent longer in police custody than those in the care of their parents or guardians. Detainees were aware of how to complain about their treatment by the police to the Office of the Police Ombudsman for Northern Ireland.

In the custody cell, safeguarding and health care

The custody suites visited were in a good state of repair and the Police Service of Northern Ireland had an ongoing maintenance programme in place. Further rationalisation of the custody estate was planned when two new build custody suites were completed.

Use of force in custody was more closely monitored than it had been previously, with patterns and trends able to be identified and analysed. A quality assurance programme was about to commence at the time of the fieldwork. Levels of force used were low in accordance with the Police Service of Northern Ireland guidance.

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Officers received annual personal safety training, including de-escalation techniques. Audio recording in cells should be improved to ensure the quality assurance process is fully effective. Strip-searching was not used excessively and was mainly used to search for drugs or objects for self-harm. Custody suites were well-stocked with supplies of food and drink, alternative clothing and wash kits. Alternative clothing was widely used but there was little recorded evidence of detainees being offered a shower or outside exercise, albeit most detainees did not stay in custody long.

The need for safeguarding was understood by Police Service of Northern Ireland officers although policies for children tended to focus more on them as victims of crime rather than potential perpetrators. The Police Service of Northern Ireland’s Public Protection Branch was the key source of advice for custody staff in this area. The Northern Ireland Appropriate Adult Scheme had been delivered by Mindwise for 10 years and was reported to work well. It was more difficult for custody staff to access a social worker to act as an appropriate adult for a child who was ‘Looked After’.

Police systems flagged previous valuable information about risks in relation to safeguarding information that was already known to police. However there were inconsistencies in the information available about wider safeguarding issues, such as children who were on the Child Protection Register. The information technology system recently developed by the Police Service of Northern Ireland to address

this (referred to in CJJ’s inspection of child sexual exploitation⁶) should also be available to custody staff. Evidence from the Police Service of Northern Ireland’s data and detainees themselves suggested that children and young people were treated with particular care in police custody.

A new nurse-led model of health care was being piloted in Musgrave custody suite in Belfast at the time of the inspection, in a partnership between the Police Service of Northern Ireland, Belfast Health and Social Care Trust and the Public Health Agency. The Police Service of Northern Ireland hoped to roll out this model across the custody estate to address significant weakness in clinical governance highlighted in previous inspections, based on a shared funding arrangement. Inspectors were encouraged by positive feedback about the potential benefits of the new model and it is recommended this model be expedited across Northern Ireland. Outside Belfast the Police Service of Northern Ireland continued to engage Forensic Medical Officers as independent contractors and Police Service of Northern Ireland staff were involved in the monitoring and planning of this service. This arrangement was set to continue until funding for the new model can be agreed and it could be rolled out. In the interim arrangements for raising concerns in respect of the individual’s practice of Forensic Medical Officers should be formalised.

The collection of data in Musgrave custody suite regarding adverse incidents was undertaken using two systems; one used

6 CJJ, Child Sexual Exploitation in Northern Ireland: *An inspection of the criminal justice system’s response, June 2020*, available online at: www.cjini.org/TheInspections/Inspection-Reports/2020/April-June/Child-Sexual-Exploitation-in-Northern-Ireland.

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by the Police Service of Northern Ireland and one by the Belfast Health and Social Care Trust. There were no mechanisms, at the time of the inspection, to share data or jointly analyse this data. This should be addressed by the development of joint systems for analysis and learning.

Access to health care professionals was generally good, with some delays in rural areas but with 24/7 cover in Musgrave custody suite. Training for custody staff in relation to health care needs should be reviewed. Facilities for provision of health care were good although arrangements for cleaning and monitoring of standards of cleanliness should be improved in order to ensure proper infection control. There were inconsistencies in the oversight and management of medical equipment, which needs to be addressed. Detainees' medical records were accessible in Musgrave custody suite but not yet outside Belfast and there was variance in the management of medical records across the suites. Arrangements for access to and management of medical records should be improved. The management of medications was also inconsistent and needs improvement.

The service provision for management of drug and alcohol misuse in custody suites was minimal. Mental health provision was delivered by the Police Service of Northern Ireland's custody staff and Forensic Medical Officers across all suites, but mental health nurses were only available as part of the new model in Musgrave custody suite. Local arrangements to provide mental health advice and support between custody suites and health care providers varied between localities and Trusts. This variation was evident in the

extent to which custody suites were used for detention of detainees who required acute mental health hospital admission under Article 130 of the Mental Health Order (Northern Ireland) 1986. It is recommended that work is undertaken to address equity of access to mental health care across the Police Service of Northern Ireland custody estate.

Release and transfer from custody

Pre-release risk assessments were not always completed appropriately before every detainee left custody and the Police Service of Northern Ireland needs to improve the quality of analysis and recording of these. Detainees were signposted to other organisations but a travel scheme should be introduced to ensure those without access to funds can get home safely.

It was challenging for the Police Service of Northern Ireland to ensure detainees were fit for interview, processed, interviewed and transported to court for the appropriate time. There was no use of video-link for first appearances at court, as there was no provision for this in the Police and Criminal Evidence (Northern Ireland) Order 1989. Saturday courts were most difficult to access. CJI welcomes the outcome of ongoing discussions between the Police Service of Northern Ireland and the Judiciary to progress these matters.

RECOMMENDATIONS

STRATEGIC RECOMMENDATIONS

STRATEGIC RECOMMENDATION 1

The Department of Justice should prioritise and secure support for required legislative reform to:

- implement longstanding Northern Ireland Law Commission recommendations on the right to bail for children and young people; and
- make changes to the Police and Criminal Evidence (Northern Ireland) Order 1989 which make provisions for alternative accommodation for children charged with an offence and provide clarity for Custody Officers on the detention of children and young people.

(paragraph 2.18)

STRATEGIC RECOMMENDATION 2

The Police Service of Northern Ireland should re-establish strategic discussions with health and social care partners to address the issue of 'Looked After' children being held in police custody cells. This should commence within three months of the publication of this report

(paragraph 2.20)

STRATEGIC RECOMMENDATION 3

The Police Service of Northern Ireland and Health and Social Care Trusts should collaborate effectively to expedite the implementation of the nurse-led custody model across Northern Ireland with interdepartmental strategic support.

(paragraph 5.57)

STRATEGIC RECOMMENDATION 4

Systems should be developed and implemented at both operational and senior managerial level within the Police Service of Northern Ireland and the Belfast Health and Social Care Trust for the joint analysis of incidents/complaints by health care professionals/Forensic Medical Officers to ensure that learning is identified and shared both between the Police Service of Northern Ireland and health care staff and between health care staff and Forensic Medical Officers across all custody suites.

(paragraph 5.57)

STRATEGIC RECOMMENDATION 5

The Police Service of Northern Ireland should develop and implement systems through locality/district based Administrative Forensic Medical Officers, Responsible Officers at the Health and Social Care Board and through the General Medical Council where required for resolving professional practice concerns or complaints. These systems should focus on continuous improvement in quality and ensuring consistency in respect of the services provided.

(paragraph 5.57)

STRATEGIC RECOMMENDATION 6

The Police Service of Northern Ireland and health care providers should define the current arrangements for the access to acute mental health care for detainees in custody suites and agree on a suitable model to ensure equity of access across Northern Ireland. These arrangements should reinforce the appropriate use of Article 130 of the Mental Health Order (Northern Ireland) 1986 which should be clearly communicated to health care professionals working in these environments.

(paragraph 5.87)

OPERATIONAL RECOMMENDATIONS

OPERATIONAL RECOMMENDATION 1

Within six months of the publication of this report, the Police Service of Northern Ireland should address gaps in Section 75 (of the Northern Ireland Act 1998) monitoring of detainees in custody, particularly in relation to community background and sexual orientation.

(paragraph 2.26)

OPERATIONAL RECOMMENDATION 2

Within three months of the publication of this report, the Police Service of Northern Ireland should review its current guidance on care plans and reinforce, through guidance issued and the quality assurance process, the need for sound decision making and better recording of care plans on the custody record that are in accordance with the College of Policing's Authorised Professional Practice for Detention and Custody.

(paragraph 4.18)

OPERATIONAL RECOMMENDATION 3

The Police Service of Northern Ireland should define the required standards in respect of the cleaning of clinical and non-clinical areas within custody suites. The Police Service of Northern Ireland must ensure robust monitoring and oversight of compliance with these standards.

(paragraph 5.64)

OPERATIONAL RECOMMENDATION 4

The Police Service of Northern Ireland should identify all health care equipment required to be held in custody suites. It must ensure systems and processes are implemented, with clearly identified roles and responsibilities, and regular audits, to ensure health care equipment is available and safe for use.

(paragraph 5.69)

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OPERATIONAL RECOMMENDATION 5

The Police Service of Northern Ireland should engage with Forensic Medical Officers and the e-health team in the Health and Social Care Board to consider arrangements for Forensic Medical Officers and health care staff to access the Northern Ireland Electronic Care Record in all custody suites. Policies and procedures should be developed and implemented to ensure clinical records are completed, stored and retained in line with professional standards and legal requirements. These should be subject to audit and compliance assured.

(paragraph 5.77)

OPERATIONAL RECOMMENDATION 6

Policies and procedures for the management of medicines should be developed and implemented to standardise processes across all custody suites and to ensure that the use of medicines in custody is in line with professional and legal requirements. This should include:

- ensuring Forensic Medical Officers access only their own individual supply of medication; and
- ensuring medicines are in date and stored securely at the appropriate temperature.

(paragraph 5.77)

OPERATIONAL RECOMMENDATION 7

The Police Service of Northern Ireland should develop an action plan to improve the quality of analysis and recording of pre-release risk assessments within three months of the publication of this report.

(paragraph 6.2)

AREAS FOR IMPROVEMENT

1. Further examination of the reasons for arrest and detention in custody of Irish Travellers and people of Black ethnicities would be beneficial to see if any improvements in practice can be identified (**paragraph 1.19**).
2. The Police Service of Northern Ireland should undertake further analysis regarding the use of sleeping reviews by Custody Inspectors and address any issues arising (**paragraph 4.33**).
3. In order to improve the quality assurance process for use of force the Police Service of Northern Ireland should:
 - establish whether it is possible to improve the coverage of audio recording in existing custody cells; and
 - ensure audio recording which records every interaction between detainees and staff in the cell is included in the specification for new build suites (**paragraph 5.13**).
4. The Police Service of Northern Ireland should introduce without delay the proposed information technology process to alert within its system children on the Child Protection Register and ensure it applies to custody records (**paragraph 5.37**).
5. The Police Service of Northern Ireland should review the provision of health care training to ensure that custody staff are equipped with the appropriate skills to effectively meet the needs of detainees (**paragraph 5.59**).
6. The Police Service of Northern Ireland should consider options for the use of a travel scheme for detainees without access to funds or transport from family or friends (**paragraph 6.6**).

CHAPTER 1: INTRODUCTION

THE NEED FOR MONITORING OF POLICE CUSTODY

- 1.1 The Association for the Prevention of Torture notes that “*Detention by the police is the moment when detainees are most at risk of ill-treatment or of suffering other types of abuse. To prevent and combat crime and to maintain public order law enforcement officers are provided with a series of powers. The police have the power to control identities, to arrest, to conduct searches, to monitor demonstrations, to detain, to interrogate, to investigate, and to use force under certain conditions. Although most police officers will always act within the strict framework of their mandate, there exist in all these steps serious risks of abuse. There is therefore a need for a proper and impartial monitoring of police conduct.*”⁷
- 1.2 The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (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.⁸
- 1.3 In 2003 the United Kingdom (UK) ratified the OPCAT and designated its NPM in 2009. At the time of this report the United Kingdom’s NPM was made up of 21 visiting or inspecting bodies that visit places of detention including prisons, police custody, immigration detention centres, children’s secure accommodation and mental health detention. The NPM is co-ordinated by Her Majesty’s Inspectorate of Prisons (HMIP). In Northern Ireland the NPM bodies who monitor police custody include CJI and the Regulation Quality and Improvement Authority (RQIA) as well as the Northern Ireland Policing Board’s (NIPB) Independent Custody Visiting Scheme. Inspections on the efficiency, effectiveness and treatment of detained persons in respect of police custody of the Police Service of Northern Ireland (PSNI) are conducted by CJI and the RQIA.

7 Association for the Prevention of Torture, *Police custody: Risks and safeguards*, APT website, online at: www.appt.ch/en/police-custody-risks-and-safeguards

8 OPCAT and the UK’s NPM, HMIP accessed online at www.justiceinspectors.gov.uk/hmiprison/national-preventive-mechanism.

LEGISLATIVE AND POLICY FRAMEWORK

- 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 C⁹ sets out the responsibilities of the police in respect of the detention, treatment and questioning of persons by Police Officers. PACE Code of Practice H¹⁰ similarly sets out the responsibilities of the police detention, treatment and questioning of persons under Section 41 of, and Schedule 8 to, The Terrorism Act 2000. The Corporate Manslaughter and Corporate Homicide Act 2007 had also covered Northern Ireland since 2012. The PSNI could therefore potentially be prosecuted for corporate manslaughter following a death in custody.
- 1.5 Authorised Professional Practice (APP) documents are published by the College of Policing as the official source of professional practice on policing and are used by police forces across England, Wales and Northern Ireland. Police Officers and staff are expected to have regard to APP in discharging their responsibilities. The APP on Detention and Custody was published in 2013 and the latest version was updated in August 2018¹¹. This set out guidance for police forces and staff in relation to custody management and planning; response, arrest and detention; moving and transporting detainees; risk assessment; control; restraint and searches; detainee care; deaths in custody; and buildings and facilities.
- 1.6 The APP set out the following principles in relation to safer detention¹²:
- there is a strategic focus, supported by the chief officer group, which promotes the safe and decent delivery of custody;
 - detention is appropriate, authorised and lasts no longer than is necessary. Forces adhere to all rights relating to PACE and the PACE Codes of Practice. While detainees are in custody, officers and staff treat them in a way that is dignified and takes account of their human rights and diverse individual needs. Custody staff are respectful in their day-to-day working and are aware of and responsive to any particular risks and vulnerabilities;
 - detainees have access to health and social care services appropriate to their physical and mental health needs. They receive emergency medical care where necessary and are provided with appropriate medication or support according to their needs;
 - any force used within a custody suite is necessary, proportionate and lawful;

9 Department of Justice Northern Ireland, *PACE Code C: detention, treatment and questioning of persons by police officers*, available online at: www.justice-ni.gov.uk/publications/pace-code-c-detention-treatment-and-questioning-persons-by-police-officers.

10 Department of Justice Northern Ireland, *PACE Code H: detention, treatment and questioning of persons by police officers under Section 41 of, and Schedule 8 to, the Terrorism Act*, available online at: www.justice-ni.gov.uk/publications/pace-code-h-detention-treatment-and-questioning-persons-under-s41-schedule-8-terrorism.

11 College of Policing, *Approved Professional Practice: Detention and custody, August 2018*, available online at: www.app.college.police.uk/app-content/detention-and-custody-2/.

12 APP, www.app.college.police.uk/app-content/detention-and-custody-2/custody-management-and-planning/#principles-of-safer-detention.

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- all Custody Officers and staff have undergone appropriate and adequate training. Police, contract and health care professionals understand their role and their legal responsibilities, and are operationally competent;
- all areas of the custody suite are clean and safe. Officers and staff keep custody facilities in a good state of repair and ensure that they are fit for purpose and meet fire safety standards;
- Officers and staff record and monitor all use of force; and
- forces must ensure that there are appropriate governance and accountability arrangements in place for contracted and commissioned staff.

BACKGROUND TO THIS INSPECTION

- 1.7 In June 2009 CJI published its first inspection of police custody, conducted in partnership with the RQIA.¹³ A follow-up review was conducted and published in February 2013.¹⁴ 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. CJI and the RQIA conducted a further full inspection which was published in March 2016¹⁵ which concluded that there had been 'some progress on police custody arrangements but further changes are required'. Consistently in these inspections concerns had been highlighted, and recommendations made around several of the aspects of health care delivery including policies and procedures surrounding the safe selection, procurement, prescription supply, dispensing, storage, administration and disposal of medications, as well as the need for an alternative health care model.
- 1.8 The inspections conducted to date utilised a set of *Expectations for police custody* developed for the rolling programme of inspections of police custody in England and Wales by HMIP and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS, formerly Her Majesty's Inspectorate of Constabulary (HMIC)). CJI and the RQIA have used the *Expectations for police custody* since the first inspection in 2009, adapted for the Northern Ireland context. The *Expectations* are independent but are informed by PACE and its Codes, professional guidance to the police on detention and custody¹⁶, and international human rights standards relevant to police custody¹⁷. They are also drawn from inspection experience and wider consultation with stakeholders, including police forces and non-

13 CJI, *Police custody: The detention of persons in police custody in Northern Ireland, June 2009*, available online at: www.cjini.org/getattachment/3d4f79c9-b015-4919-a9a2-416247266efa/Police-Custody-The-detention-of-persons-in-police.aspx

14 CJI, *Police custody: a follow-up review of the inspection recommendations, February 2013*, available online at: www.cjini.org/TheInspections/Action-Plan-Reviews-Inspection-Follow-Up-Review/2013/Police-Custody

15 CJI, *Police custody: The detention of persons in police custody in Northern Ireland, March 2016*, available online at: www.cjini.org/TheInspections/Inspection-Reports/2016/January---March/Police-Custody

16 College of Policing, *Authorised Professional Practice on Detention and Custody, July 2015 version*, available online at: www.app.college.police.uk/app-content/detention-and-custody-2/

17 Association for the Prevention of Torture, *Monitoring Police Custody – a practical guide, 2013*, available online at: www.ap.t.ch/en/resources/monitoring-police-custody-a-practical-guide/

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police groups. They incorporate learning from HMICFRS’s thematic inspection of the welfare of vulnerable people in police custody¹⁸ and from the cumulative experience of joint inspections of police custody to date.

1.9 The *Expectations* for England and Wales were updated in May 2018, solely to reflect the requirements of the Policing and Crime Act 2017 in relation to bail and the introduction of released under investigation (see ‘Access to swift justice’). As this legislation is not applicable to Northern Ireland, the *Expectations* in this area still reflect existing provisions in relation to bail.

1.10 The 2018 version of the *Expectations* were adapted for use in Northern Ireland and agreed with the PSNI. The five inspection areas were:

- Leadership, accountability and partnerships;
- Pre-custody: first point of contact;
- In the custody suite: booking in, individual needs and legal rights;
- In the custody cell, safeguarding and health care; and
- Release and transfer from custody.

A copy of the *Expectations* used in the inspection can be found at Appendix 1.

The 2019 inspection

1.11 In preparation for this inspection the Lead Inspector from CJI accompanied partner Inspectorates on custody inspections in Glasgow (Police Scotland) and Exeter (Devon and Cornwall Police) as an observer. Information, documents and data templates were shared by partners to assist in the development of the methodology for this inspection, particularly in relation to the case reviews and audits. Full details of the methodology can be found in Appendix 2.

1.12 The terms of reference for this inspection can be found at Appendix 3. In preparation for the fieldwork CJI conducted a survey of prisoners who had recently been committed to Maghaberry Prison (adult males), Hydebank Wood Secure College (young people aged 18 to 21 years), Ash House Women’s Prison (adult females) and the Woodlands Juvenile Justice Centre (Woodlands JJC) (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 suite, provision of food, drinks, clothing and bedding, safety and treatment by custody staff, access to legal representatives and health care professionals, and background details of the detainee themselves. The results of the 2019 survey compared to the responses collected in 2015 can be found in Appendix 4.¹⁹

18 Vulnerability is linked, in many cases, to a minority status that increases the risks of stigmatisation and ill-treatment. Individuals therefore may be vulnerable in a given context and not in another. HMIC, *The welfare of vulnerable people in police custody, March 2015*, available online at: www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/the-welfare-of-vulnerable-people-in-police-custody.pdf.

19 Questions have only been compared where the same/similar question was asked in the survey for the 2016 report.

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1.13 Case file reviews of custody records on the NicheRMS (Records Management System developed by Niche Technology Inc. and used by the PSNI) were undertaken by CJI Inspectors using a methodology adapted from that used by HMIP, HMICFRS and Her Majesty's Inspectorate of Constabulary in Scotland (HMICS) (see Appendix 2). A full list of custody records from October 2019 were provided by the PSNI; comprising 2,212 records in total. From this records were selected and reviewed as follows:

- 100 cases reviewed for a Case Review Analysis (adults and children);
- 37 additional cases reviewed where the detainee was a child for the Case Review Analysis; and
- 40 cases reviewed for Thematic Case Reviews: 10 cases selected across four case types where the detainee was a) a child; b) intoxicated; c) had identified or reported mental health issues; d) was subject to use of force while in custody. The Closed-Circuit Television (CCTV) footage of these 10 cases as well as three other cases where force was used in custody was reviewed.

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 NicheRMS.

1.14 Meetings were held between CJI and a number of stakeholders in advance of the inspection including senior managers and reception staff from the two prisons, the Northern Ireland Prison Service Prisoner Escorting and Court Custody Service and Woodlands JJC. Inspectors also spoke with the Office of the Police Ombudsman for Northern Ireland (OPONI), the Northern Ireland Policing Board (NIPB) Independent Custody Visitors (ICVs) and the Scheme Administrator/ Manager, Mindwise (who deliver the Northern Ireland Appropriate Adult Scheme; (NIAAS)), the Northern Ireland Commissioner for Children and Young People, the Equality Commission for Northern Ireland, the Criminal Law Committee of the Law Society for Northern Ireland, the Department of Justice (DoJ) and Department of Health (DoH). Relevant documentation and statistics were also reviewed. The PSNI undertook a self-assessment against the *Expectations*, providing supporting documentation and custody data.

1.15 Fieldwork was undertaken by CJI and the RQIA with the PSNI over a two week period in December 2019. Throughout this period Inspectors undertook unannounced visits to eight custody suites (every suite which was operational at the time). During these visits Inspectors spoke to the Custody Officer and Custody Detention Officers (CDOs), as well as any cleaning staff, solicitors, health care professionals and others providing services to the detainees present (for example, appropriate adults). In addition, detainees in the custody suite were asked the same set of questions from the detainee survey as described earlier. Focus groups and interviews were also held with those in District Policing Command and corporate services responsible for custody planning, policy and oversight as well as operational staff from custody suites.

1.16 Inspectors from CJI and the RQIA assessed the evidence collected against each of the *Expectations*. CJI Inspectors were responsible for inspecting the *Expectations* relating to criminal justice issues with RQIA Inspectors inspecting those within Section 4 relating to health care (governance of health care, patient care, substance use and mental health).

The police custody population detained by the PSNI

1.17 In preparation for the inspection the PSNI was asked to provide a range of data relating to their custody population over the previous year including overall population figures for the last three years. Data was provided on the numbers of detainees arrested and brought to custody ('throughput')²⁰ as follows for both age (Table 1), gender (Table 2) and by ethnicity (Table 3). The PSNI do not currently monitor community background of detainees (see Chapter 2).

Table 1: Custody population for 2016-17 to 2018-19 by age

	2016-17		2017-18		2018-19	
	No.	%	No.	%	No.	%
Adults	22,413	92%	23,271	92%	24,337	93%
<i>(of which were vulnerable adults)</i>	(1,814)	(7%)	(2,226)	(9%)	(2,536)	(10%)
Children & young people (aged under 18 years)	1,951	8%	2,072	8%	1,823	7%
<i>(of which aged under 17 years)</i>	(1,511)	(6%)	(1,581)	6%	(1,326)	(5%)
<i>(of which were aged 17 years)</i>	(440)	(2%)	(491)	2%	(497)	(2%)
Total	24,364		25,343		26,160	

Where percentages do not add up to 100% this is due to rounding issues

The figures for age show a steady year on year increase in the number and proportion of adults who are determined to be vulnerable²¹ and therefore required the services of an appropriate adult. The numbers and proportion of children had remained fairly consistent with a slight decrease in 2018-19.

20 This is the number of cases in total brought into custody; some of these case will relate to the same individuals who have been arrested and detained more than once during the year.

21 PACE (Northern Ireland) Code C outlines that 'Mentally vulnerable' applies to any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies. 'Mental disorder' is defined in Article 3(1) of the Mental Health (Northern Ireland) Order 1986 as 'mental illness, mental handicap and any other disorder or disability of the mind'. When the custody officer has any doubt about the mental state or capacity of a detainee, that detainee should be treated as mentally vulnerable and an appropriate adult called. See PACE (Northern Ireland) Code C at <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/16-06-pace-code-c-2015.pdf>.

Table 2: Custody population for 2018-19 by gender

	Number	%
Male	21,903	84%
Female	4,251	16%
Transgender	4	0%
Failed to record	2	0%
Total	26,160	

The figure of 16% of detainees being female was an increase of 1% from the consistent rate of 15% since 2012-13²². Inspectors did not find any evidence in the inspection to explain why this increase may have occurred, and it may not indicate a longer term trend, but Inspectors would encourage the PSNI to continue to monitor this over time.

Table 3: Custody population for 2018-19 by ethnicity*

Ethnicity	Number	%
White	24,609	94.1%
Irish Traveller	737	2.8%
Indian	41	0.2%
Pakistani	34	0.1%
Bangladeshi	15	0.1%
Other Asian	36	0.1%
Black Caribbean	21	0.1%
Black African	146	0.6%
Black Other	111	0.4%
Chinese	70	0.3%
Other Ethnic Group	244	0.9%
Mixed Ethnic Group	45	0.2%
Roma	50	0.2%
Gypsy	1	0.0%
Total	26,160	

* Where the total does not equal 100% this is due to rounding issues

22 See the PSNI's Annual Police and Criminal Evidence Order (PACE) Statistics online at www.psnipolice.uk/inside-psni/Statistics/police-and-criminal-evidence-pace-order-statistics/.

1.18 At 94.1% detainees who were of white ethnicity were clearly the majority group as would be expected. Irish Travellers account for the next largest group at 2.8% of the total. The CJI inspection of equality and diversity monitoring in the criminal justice system²³ noted the over-representation of members of the Irish Travelling Community in stop and search statistics stating: *“Statistics for 2016-17 provided by the PSNI for all stop and search activity show that 2.34% of stop and searches related to members of the Travelling Community. The figures for the two previous years are similar: 2015-16 was 2.37% and 2014-15 was 2.25%. Although now dated, 2011 Northern Ireland Census data shows members of the Travelling Community represented 0.07 percent of the Northern Ireland resident population. This data would suggest that further exploration is warranted. As with children and young people, an examination of the different types of outcomes arising from this stop and search activity would also be beneficial.”*

1.19 Similarly the figures for this inspection suggest that members of the Irish Travelling Community are also over-represented in relation to detention in custody. It is unclear from this inspection why Irish Travellers appear to be over-represented in custody and Inspectors found nothing in the file reviews to indicate that Irish Travellers were inappropriately arrested, detained or denied bail. The PSNI custody team was aware of the disproportionate numbers via their monthly monitoring process but work had not yet been undertaken by the organisation to try and examine why this existed. The figures also indicate an over representation of people from black ethnicities (Black African, Black Caribbean and Black Other) who accounted for 1.1% of all those arrested by the PSNI in 2018-19 but only account for around 0.2% of the population²⁴. **Area for improvement: further examination of the reasons for arrest and detention in custody of Irish Travellers and people of Black ethnicities would be beneficial to see if any improvements in practice can be identified.**

RISKS AND NEEDS OF DETAINEES IN CUSTODY

1.20 The Case Review Analysis provided a snapshot of the complex needs of and risks presented by detainees which custody staff dealt with on a daily basis. The box below provides a summary of data obtained from custody records provided by the PSNI.

23 CJI, *Equality and diversity within the criminal justice system: An inspection of the implementation of section 75 (1) of the Northern Ireland Act 1998, September 2018*, available online at: www.cjini.org/getdoc/94cca2ae-524d-43cd-b17b-a9c0856c8aaa/Equality-and-Diversity-within-the-Criminal-Justice.aspx.

24 NISRA reported in 2013 that based on main ethnic group, 0.2 per cent of (3,600) of people usually resident in Northern Ireland on Census Day 2011 were Black. See NISRA, *Census 2011: Detailed Characteristics for Northern Ireland on Ethnicity, Country of Birth and Language, June 2013*, available online at: www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/2011-census-results-detailed-characteristics-statistics-bulletin-28-june-2013.pdf.

Detainee needs and risk assessment data from custody records reviewed

Of the 100 custody records reviewed:

- 45% of detainees were recorded as having consumed **alcohol** in the last 24 hours and 12% declared they had an **alcohol dependency**;
- 19% of detainees were recorded as having consumed **drugs** in the last 24 hours and 15% confirmed they had a **drug dependency**;
- 19% of detainees were recorded as ever having attempted **suicide or self-harm** with 12% who admitted they had thoughts of suicide or self-harm currently;
- 53% of detainees were recorded as having **mental health issues**;
- 7% of detainees were recorded as having a **disability**, 18% had a difficulty with **reading or writing** and 25% were recorded as having another **vulnerability** issue; and
- 22% of detainees required the services of an **appropriate adult** and 5% the services of an **interpreter**.

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.).

Data provided by the PSNI for 2018-19 showed that:

- **30%** of detained persons in custody required Level 1 **general observation** (checked at least every hour);
- **43%** required Level 2 **intermittent observation** (visited and roused at least every 30 minutes);
- **26%** required Level 3 **constant observation** (constantly observed using closed-circuit television (CCTV) in addition to physical checks at least every 30 minutes); and
- **0.4%** required Level 4 **close proximity** (detainee physically supervised in close proximity).

1.21 The data shows the significant levels of risks and needs of the detainee population, particularly given that many of the detainees had two or more of these risks and needs. The need for a multi-disciplinary approach to this issue has been highlighted by the Chief Constable at the NIPB²⁵ who stated: "There is an acceptance among partners that in terms of reducing the harm caused it is primarily a matter of public health rather than a criminal justice issue. The impact of drug and alcohol dependency and related mental health issues are evident in the police custody environment. Nearly a third of detained persons show signs of intoxication through drugs or alcohol. This was confirmed on 23 December 2019 during a meeting between senior leaders from the Department of Health, Department of Justice, Public Health Authority and the PSNI. This meeting discussed Northern Ireland drug related deaths and was chaired by the Chief Medical Officer, Dr Michael McBride."

25 Chief Constable's report to NIPB, 6 February 2020, available on-line at:
www.psnipolice.uk/news/Latest-News/060220-chief-constables-report-to-nipb/.

CHAPTER 2: **LEADERSHIP, ACCOUNTABILITY AND PARTNERSHIPS**

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

EXPECTATION - LEADERSHIP

Leadership by the Chief Officer Group

- 2.1 The PSNI's Custody Policy stated "We are committed to the highest standards of treatment for persons arrested, detained and subsequently departing from custody, either on release or on transfer to other partners in the criminal justice system. We accept that detained persons should be treated humanely, fairly, expeditiously and in accordance with the law."²⁶ The PSNI's Service Instruction on Youth Justice²⁷ set out the PSNI approach to dealing with young people for the service stating "Careful consideration must be given to the 'necessity' criteria before arresting any child, but particularly when a child is looked after by an authority ('Looked After' Child)". The PSNI's custody policy also stated "Particular cognisance must be given to protecting the rights and addressing the needs of children, young people and other vulnerable persons. Custody should be considered as a last resort for children." The Youth Diversion Scheme was well embedded in the PSNI and diversionary options such as community resolutions, community restorative justice schemes, informed warnings, restorative cautions and youth engagement clinics were utilised as an alternative to dealing with offences by way of arrest and charging.
- 2.2 Local Policing Officers confirmed that diversionary options were available to them and were key considerations when dealing with children and young people or those who were particularly vulnerable, for example those with mental health issues. There were however practical difficulties in applying these options.

26 PSNI, *Service Policy SP0218: Custody, May 2018*, available online at: www.psni.police.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/custody-service-policy-310518b-external---policenet-link-removed.pdf.

27 PSNI, *Service Instruction SI0817: Youth Justice, January 2017*, available online at: www.psni.police.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/youth-justice---external-120517.pdf.

- 2.3 The Assistant Chief Constable for District Policing Command had overall responsibility for Safer Detention and Custody, both in respect of the governance and accountability provided by District Policing Command as well as the operational command of the custody functions in the PSNI's policing districts. The Custody Strategic Group, chaired by the Chief Superintendent in District Policing Command, met monthly to govern the custody function. Custody issues of wider significance were escalated to service governance boards, chaired by the Deputy Chief Constable, such as the Service Change and Service Performance Boards. A Custody Operational Group, chaired by a Chief Inspector, District Policing Command, met quarterly to enable operational matters to be reviewed and amended as required. At both strategic and operational levels there was appropriate representation from key delivery areas within the PSNI and from partner organisations who provided services in custody.
- 2.4 The Custody Policy, provided an overview of the policy framework for the PSNI's management and delivery of custody containing references to relevant legislation, oversight bodies and national and local guidance (such as the College of Policing Detention and Custody APP). Custody staff could access the Custody pages of the PSNI's intranet site which contained relevant training information, guidance documents and service updates and there were regular emails shared by the custody team in District Policing Command to clarify issues or point to new or amended guidance.
- 2.5 At the time of the inspection the PSNI had eight custody suites in operation. This was a significant reduction from CJI's first inspection (when the PSNI had 21 custody suites with a total cell capacity of 144) and in line with the PSNI's custody estate strategy. In addition, at the time of the visits in December 2019 one suite (Strand Road) was closed for planned refurbishment to upgrade the medical room, one was mothballed (Bangor) and one was closed pending decisions about significant refurbishment/re-building (Enniskillen). The operational capacity in terms of cells is shown in Table 4.

Table 4: Cell capacity of the PSNI estate

Station	Cell capacity
Operational suites (December 2019)	
Antrim	20
Banbridge	7
Musgrave (Belfast)	50 (including the Terrorism Act cells)
Coleraine	10
Dungannon	5
Lurgan	6
Omagh	10
Strand Road (Derry/Londonderry) (closed for six weeks planned refurbishment during period of inspection)	10
Total	118
Closed suites	
Bangor (mothballed)	7
Enniskillen (pending decision about refurbishment)	8
Strabane (mothballed but open during period of inspection while Strand Road was closed)	7

2.6 Suites were staffed by Custody Sergeants and CDOs who had completed training courses specific to their role, both of which had the theme of vulnerability running throughout. Both courses covered the areas of risk assessment, safety and welfare of detainees (including dealing with detainees with vulnerabilities), suicide awareness and first aid and the personal safety programme as well as issues specific to the role (for example, bail and the NIAAS for Custody Sergeants). The courses were both classroom based and included experiential learning through shadowing in a custody suite. The PSNI also ran a Custody Constable course to train officers who may be required to work in the custody suite on a more infrequent basis to fill gaps in resource. Again vulnerability was a significant focus of this course. Mental health issues and drugs were highlighted to Inspectors as areas where staff would welcome greater input in training and continuous professional development.

2.7 In the 2016 inspection report CJI recommended that the PSNI should ‘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)’. In 2016 the CDOs were provided under a managed service contract but in September 2017, the service was transferred into the PSNI, with the CDOs employed as police staff. At the time of this inspection the staffing model continued to remain fairly static; with consistent numbers of Custody Sergeants and CDOs allocated to each suite, regardless of day or predicted demand. The PSNI had begun however to review staffing levels; the consistency of staffing levels across North and South policing regions was being considered as well as a project looking at resource levels in Musgrave custody suite and trying to utilise resources better to deal with times of increased volume. CJI looks forward to the outcome of this work but appreciates the difficulties in predicting demand. As the Case Review Analysis for this inspection indicated, it is difficult to anticipate times of highest demand during the week with the exception of Saturday night/Sunday morning when there will be increased numbers of detainees awaiting transfer to court on Monday morning.

Protection of children and vulnerable adults

2.8 The DoH’s policy ‘Co-operating to safeguard children in Northern Ireland’²⁸ set out the policy framework for agencies to work together, including the PSNI and Health and Social Care Trusts (HSCTs). This covered the various aspects or circumstances in a child’s life which may make them in need of safeguarding and the organisations which have these responsibilities. However this was mainly from the perspective of a child as a victim of crime rather than those involved in offending. The policy document did not set out how information on children who were involved with social services for safeguarding purposes would be shared between the organisations.

2.9 Custody staff were aware of the need to safeguard children and had been made aware of the signs of child sexual exploitation. There were posters in every custody suite about child sexual abuse and exploitation and the need to inform and involve the PSNI’s Public Protection Branch. Staff were less able to articulate the signs of human trafficking, extortion and smuggling and what to do if they perceived the detainee had potentially been a victim of trafficking. Training in this area will be reviewed in CJI’s inspection of human trafficking and modern slavery with a report anticipated later this year.

2.10 While the PSNI did not have specific objectives around avoiding the criminalisation of children it was clear that this approach was well understood by custody staff, particularly for younger children. There was evidence of practice in this area to avoid holding children in the custody suite where possible (see Chapter 5).

28 Department of Health, *Co-operating to Safeguard Children and Young People in Northern Ireland, version 2.0, August 2017*, available online at: www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland.

2.11 Difficulties arose however in the approach to children who were ‘Looked After’ children resident in a children’s home who offended in the home (for example, caused criminal damage or assaulted a member of staff) or went missing and offended in the course of being returned to the home by police (for example, assaulted the police officers, arrested for disorderly behaviour). Figures provided by the Health and Social Care Board (HSCB), relating to the reporting of ‘untoward incidents’ by HSCTs involving a child in care²⁹, show that 80 children were detained by the PSNI for more than four hours during 2018-19, with a total of 179 incidents reported (with some children being detained on more than one occasion).

2.12 While not strictly analogous, CJI has compared these figures and the reported total number of children in care, aged 12-17, with the figures provided by the PSNI showing the number of children arrested during 2018-19 and population estimates reporting the total number of children resident in Northern Ireland in mid-2018. These comparisons are outlined in Table 5. While this is an estimation it significantly illustrates the much greater likelihood that a child who is in care will be arrested by the police than a child not in care. This will be as a result of a number of complex reasons but is worthy of further work by statutory agencies.

Table 5: Comparisons of children in care versus not in care and detention by the PSNI

	Total	In care*		Not in care	
		No.	%	No.	%
Children in Northern Ireland (age 12-17)**	136,714	1,378	1%	135,336	99%
PSNI throughput of children (age 10-17)***	1,326	179****	13%	1,147	87%

* Children in care as reported in DoH Children’s Social Care Statistics for Northern Ireland 2018-19, October 2019, www.health-ni.gov.uk/sites/default/files/publications/health/child-social-care-18-19.pdf. This data is reported on by grouping and therefore these figures relate to children aged 12-15 years and 16 years and over.

** Children resident in Northern Ireland as reported in NISRA 2018 Mid Year Population Estimates for Northern Ireland, June 2018, www.nisra.gov.uk/publications/2018-mid-year-population-estimates-northern-ireland.

*** Data provided by the PSNI on juveniles detained in custody for the purposes of this inspection. This relates to those children over the criminal age of responsibility i.e. 10-17 years.

**** Data provided by the HSCB for the purposes of this inspection showing untoward events for young people detained by PSNI for a period greater than four hours. These children range from 11-12 years to 17 years.

29 The HSCB collates data from HSCTs on untoward events relating to children in need of protection and looked after children. This includes a variety of categories of incident including children who are detained by the PSNI for more than four hours. Reporting is required for any child in need of protection or who is a ‘Looked After’ child in any type of placement for example in foster care, placed with parents, in residential care and in other types of placement.

2.13 Cases involving ‘Looked After’ children often had delays in processing and release from the custody suite due to the lack of provision of an appropriate adult from social services (either from the children’s home or from the on-call social worker) or the lack of alternative accommodation (for example bail fostering, secure care) until they could be accepted back to their original children’s home. In the case reviews there were cases where children arrested late at night or in the early hours of the morning were held in custody until the middle of the following morning because of the lack of a social worker to act as appropriate adult for the purposes of processing or interview. Case example 1 illustrates this issue.

Case example 1

Police were called to a children’s home following reports of damage to a fire panel and a resident assaulting a staff member. While police were attending staff reported the resident smashed a second fire panel and assaulted staff. A 16-year-old boy was arrested and taken to custody. He was under an interim care order.

The boy arrived at the custody suite just before 7 o’clock in the evening. The children’s home advised they were short-staffed and had no free social workers to act as an appropriate adult. The out-of-hours social worker was to be contacted when required. The boy requested to speak to a staff member at a children’s home he was previously resident and they were called.

The arresting officer advised the Custody Sergeant he needed to return to the children’s home to record statements and would speak to staff about performing the role of an appropriate adult for interview. The staff at the children’s home who the boy spoke to were asked by him to provide an appropriate adult for interview but they were unable to assist as they did not have enough staff on duty.

At 20:37 the arresting officer attended the second children’s home but they confirmed no-one there could act as appropriate adult. A note on the record confirmed that the interview team would need to arrange an out-of-hours social worker to attend.

At 22:19 the first children’s home phoned custody for an update; they were informed the Investigating Officer had not advised of the interview time yet and asked whether they were able to get an out-of-hours social worker organised. At 22:57 the Duty Sergeant in the area was contacted by custody who said he would try and get hold of the out of hours social worker and keep the custody staff updated. At 00:08 an update on the record stated that the Sergeant was still awaiting an estimated time of arrival from the social worker.

At 09:24 the next morning the record noted that the Investigating Officer was still awaiting a reply from Social Services regarding the social worker’s attendance for interview. At 09:29 a social worker rang and asked to be notified when the police and solicitor were ready for interview.

Case example 1 (continued)

At 12:47 the Volume Crime Support Team briefed custody to say they had not been able to obtain a social worker; at this point the boy had been in custody approximately 19 hours and police were unable to get an appropriate adult from social services to attend. NIAAS were then contacted and agreed to act as appropriate adult and attended at 13:09. At 15:03 that afternoon he was granted unconditional bail to attend youth court 10 days later.

During the period of detention the boy remained on Level 3 observations (constant observation by CCTV with physical checks every 30 minutes) as he had anxiety, was addicted to medication and had attempted self-harm about four weeks previously. He was in custody for 21 hours and 18 minutes in total.

- 2.14 In the 2016 inspection report CJI discussed at length the legislation and guidance surrounding the issue of the duty on social services to provide accommodation for 'Looked After' children and the various legislative requirements placed upon agencies by PACE and the Children (Northern Ireland) Order 1985, particularly Article 21³⁰. The judicial review brought by MP (a minor) against the decision of the Belfast HSCT in 2014³¹ was also highlighted. CJI recommended in that report *“that legislative reform is required in the following areas. It is recommended that the DoJ should:*

30 Article 21 of the Children’s (Northern Ireland) Order 1985 states:

Provision of accommodation for children: general

21.—(1) Every authority shall provide accommodation for any child in need within its area who appears to the authority to require accommodation as a result of—

- (a) there being no person who has parental responsibility for him;
- (b) his being lost or having been abandoned; or
- (c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

(2) where an authority provides accommodation under paragraph (1) for a child who is ordinarily resident in the area of another authority, that other authority may take over the provision of accommodation for the child within—

- (a) three months of being notified in writing that the child is being provided with accommodation; or
- (b) such other longer period as may be prescribed.

(3) every authority shall provide accommodation for any child in need within its area who has reached the age of 16 and whose welfare the authority considers is likely to be seriously prejudiced if it does not provide him with accommodation.

(4) An authority may provide accommodation for any child within the authority’s area (even though a person who has parental responsibility for him is able to provide him with accommodation) if the authority considers that to do so would safeguard or promote the child’s welfare.

(5) An authority may provide accommodation for any person who has reached the age of 16 but is under 21 in any home provided under Part VII which takes children who have reached the age of 16 if the authority considers that to do so would safeguard or promote his welfare.

(6) Before providing accommodation under this Article, an authority shall, so far as is reasonably practicable and consistent with the child’s welfare -

- (a) ascertain the child’s wishes regarding the provision of accommodation; and
- (b) give due consideration (having regard to his age and understanding) to such wishes of the child as the authority has been able to ascertain.

Available online at: www.legislation.gov.uk/nisi/1995/755/article/21.

31 MP’s (a minor) Application [2014] NIQB 52, available online at: judiciaryni.uk/judicial-decisions/2014-niqb-52.

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- 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)."

2.15 At the time of this inspection, due to other legislative priorities of the Justice Minister and the Committee for Justice, and the subsequent lack of an Assembly between 2017 and 2020, that recommendation had not been progressed and Inspectors were advised this would not be brought forward before the next Assembly mandate. The Northern Ireland Commissioner for Children and Young People note on their website in relation to the judicial review brought by MP (a minor) that *"Unfortunately this case is not unique and the issues raised in MP's matter remain a concern for the Commissioner. Since judgment was handed down, the Commissioner's Legal & Investigations Department has been contacted on behalf of several young people facing the same difficulties as those encountered by MP in securing a bail address from their Health and Social Care Trust when they themselves have none to put forward."*³²

2.16 Since the previous inspection a further judicial review was heard in 2018 in the case of OC (a minor) and LH (a minor) which also considered the duties required by the respective HSCT ("The Trusts") to provide accommodation to children when either 'Looked After' or children in need. In this judgment Mrs Justice Keegan noted: *"This case involves the interplay between the care system and juvenile justice. In terms of criminal justice it is important to state the cardinal principles that juvenile defendants are entitled to the presumption of innocence and that there is a presumption of bail and that a loss of liberty engages Article 5. The Trusts' knowledge of such juveniles may differ depending on the circumstances of each case. But in any event the duty upon the Trusts is to provide accommodation."* The PSNI also made submissions in this case as it involved the suitability of accommodation for young people who required a bail address (albeit post-charges rather than from police custody). In conclusion in this case, Mrs Justice Keegan made the following headline points:

- The Trust's duty under Article 21 is absolute.
- Accommodation must be provided within a reasonable time.
- That will depend on the facts of each case but there is an obvious urgency when a juvenile's liberty is at issue.
- The accommodation should be suitable.
- What is suitable will depend on the facts of each case.

32 Northern Ireland Commissioner for Children and Young People, *MP's (a minor) Application [2014] NIQB 52*, available online at: www.niccy.org/media/1439/niccy-intervention-mps-a-minor-application-2014-niqb-52.pdf.

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- *Bed and breakfast/hotel accommodation must only be used in exceptional circumstances, for the shortest possible period and accompanied by supports and services.*
- *There must be notification to the Health Board in accordance with the policy.*
- *Social services will be expected to vouch all attempts to find suitable accommodation to a court and to set out the exact nature of temporary accommodation with an emphasis on supports and services.*

2.17 DoJ youth justice policy leads confirmed that they had been analysing recommendations for changes to the Northern Ireland legislation governing bail and remand as it applies to children in the justice system that were contained in a number of independent reviews and reports, including the Northern Ireland Law Commission Report - Bail in Criminal Proceedings 2012³³ and the Cross-Departmental Scoping Study of the Youth Justice System 2016 (DoJ). As a result of their considerations, policy leads were proposing the introduction of a suite of changes to bail and remand legislation to:

- strengthen the existing automatic presumption of bail for children, introducing unconditional bail as standard, and a requirement that any conditions applied should be proportionate and relevant to the offence(s); and
- introduce specific conditions which must be met before a child can be remanded in custody.

The intention was that these provisions would be carried forward in a Justice Bill, which was expected to be introduced to the Northern Ireland Assembly in early 2021.

2.18 Inspectors look forward to the outcomes of this work but still believe that a Bail Act, or an alternative legislative mechanism, is necessary and long overdue. This is required to address the issues of bail for children and young people and support Custody Officers in being able to release children from custody as soon as possible to a suitable address, this being key, with appropriate changes made to PACE. Whilst it is appreciated that the Minister has other priorities, which do not include a Bail Act, for this Assembly mandate³⁴ it is important that work is addressed with a view to delivering in this area during the next.

33 Northern Ireland Law Commission, *Report Bail in Criminal Proceedings, September 2012*, available online at: www.nilawcommission.gov.uk/32432_-_bail_report_nilc14_2012_.pdf.

34 Northern Ireland Assembly, *Committee for Justice: Official report (Hansard): Key issues, priorities and legislative programme: Mrs Naomi Long MLA, Minister of Justice, 27 February 2020*, available online at: aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?AgendaId=21517&evidID=11657.

STRATEGIC RECOMMENDATION 1

It is recommended that the Department of Justice should prioritise and secure support for required legislative reform to:

- implement longstanding Northern Ireland Law Commission recommendations on the right to bail for children and young people; and
- make changes to the Police and Criminal Evidence (Northern Ireland) Order 1989 which make provisions for alternative accommodation for children charged with an offence and provide clarity for Custody Officers on the detention of children and young people.

2.19 As noted in the previous CJI police custody report, the duty on HSCTs to provide accommodation for children held in police custody has not yet been tested before the courts. However a legal challenge brought in England at the time of writing this report highlights the very real possibility that such a case could be taken in Northern Ireland in future. In February 2020 a children's rights organisation, Just for Kids Law, brought a legal challenge in the High Court against the London Borough of Waltham Forest for failing to provide secure accommodation for children, who are unlawfully kept overnight in police cells due to a shortage of appropriate accommodation³⁵. In recognition of the widespread nature of this problem in England, the Secretary for State for Education, the London Councils and the Association of Directors of Children's Services, along with the Metropolitan Police were all named by the court as interested parties to the case.

2.20 At the time of the inspection previous strategic work to try and address the ongoing issue of young people entering the justice system from residential care had lapsed.

STRATEGIC RECOMMENDATION 2

It is recommended that the Police Service of Northern Ireland should re-establish strategic discussions with health and social care partners to address the issue of 'Looked After' children being held in police custody cells. This should commence within three months of the publication of this report.

2.21 There was no liaison or multi-agency Article 130 (of the Mental Health (Northern Ireland) Order 1986) group but police custody was rarely used as a place of safety under Article 130. Figures provided by the PSNI indicated that police custody was used 47 times under Article 130 in 2018-19. Whilst the legislation surrounding the detention of persons with mental health issues was due to be changed once the Mental Capacity Act (Northern Ireland) 2016 was enacted, this still provided for

35 Just for Kids Law, *Children unlawfully held in police cells, February 2020*, available online at: justforkidslaw.org/news/children-unlawfully-held-police-cells.

the use of police custody as a place of safety³⁶. In respect of children, the United Nations Committee on the Rights of the Child, during its last examination of the UK, recommended that the UK Government '*Expedite the prohibition of placing children with mental health needs in adult psychiatric wards or police stations, while ensuring the provision of age-appropriate mental health services and facilities*'; (para 61(c))³⁷. Inspectors would encourage the PSNI to continue to resist all attempts to use police custody as a place of safety, given that it is an unsuitable environment for those suffering with mental health issues.

- 2.22 The PSNI's Service Instruction on Adult Safeguarding³⁸ referred to the Northern Ireland Adult Safeguarding Policy '*Adult Safeguarding: Prevention and Protection in Partnership*'³⁹ but focussed on the needs of adults at risk of harm and adults in need of protection as victims of crime rather than potential perpetrators. The Northern Ireland Safeguarding Policy itself also focussed on adults at risk of harm/in need of protection as victims but did include the underlying principles about consent and capacity, which are relevant to the custody environment.

EXPECTATION - ACCOUNTABILITY

Use of performance management data

- 2.23 The PSNI continued to undertake analysis of the performance data around custody with information being provided to the Custody Strategic and Operational Groups around staffing, throughput, risk assessments, observation levels, cell closures and demographics of detainees. This was scrutinised at the meetings and used to make decisions about custody delivery, operational planning and to address emerging issues where appropriate. A custody strategic group action register tracked the progress of actions with clear allocation of responsibilities to the appropriate areas and individuals.
- 2.24 Since the last inspection the PSNI was undertaking a greater level of ongoing scrutiny with regular quality assurance undertaken of custody records on NicheRMS by District Policing Command. This included the recording processes and justification for decision making around non-authorisation of detention, risk assessments and observation levels, flagged information and warnings, Police National Computer checks and adverse incidents. Quality assurance of use of force in custody had just begun. Feedback was given to Custody Officers by the quality assurance team on the results. Inspectors were impressed by the quality assurance

36 See www.legislation.gov.uk/nia/2016/18/section/160.

37 UNCRC, *Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland, July 2016*, available online at: tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGBR%2fCO%2f5&Lang=en.

38 PSNI, *Service Instruction SI2517: Adult Safeguarding, June 2017*, available online at: www.psnipolice.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/adult-safeguarding-290617.pdf.

39 Departments of Health and Justice, *Adult Safeguarding: Prevention and Protection in Partnership, July 2015*, available online at: www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf.

work undertaken by the custody team to scrutinise custody records, develop guidance documentation and undertake site visits to custody suites in order to enhance consistency in delivery across the PSNI. With experienced former custody staff being involved in the team they offered a source of advice and guidance to custody staff and regularly worked in the custody suites themselves to keep their skills and knowledge up to date. A Chief Inspector also represented the PSNI at national custody forums to keep updated on developments in England and Wales. The PSNI could enhance the quality assurance process by including analysis of strip-searching and complaints in custody.

- 2.25 The PSNI's Health and Safety Branch were represented at the custody operational group and in District meetings as well as on custody staff training courses. The Branch worked closely with District Policing Command to analyse adverse incidents reported to learn from issues arising. Since the last inspection CDOs had been enabled to report incidents on utilising technology and there was daily analysis of reports. The Health and Safety Branch had worked with custody staff to gather data around the incidence of spitting in custody to inform decisions around the use of spit-guards. Significant issues were escalated to the PSNI's Executive Safety Committee and shared with partner agencies.

Equality and diversity

- 2.26 The booking in process as guided by the custody record on NicheRMS included asking the detainee for relevant demographic details as per Section 75 (of the Northern Ireland Act 1998) guidance, with the exception of community background and sexual orientation. The PSNI data analysis outlined above included reviewing the Section 75 data collected to identify patterns and trends. CJI has previously reported on the PSNI's response to its Section 75 duties in the 2018 report 'Equality and Diversity within the Criminal Justice System'⁴⁰. This highlighted the gaps in monitoring across the system, including by the PSNI and made the following recommendation: *"Within six months of the publication of this report, each of the agencies inspected should review their s.75 monitoring arrangements in relation to relevant functions. Actions to address gaps in s.75 monitoring and explain disparities that have been identified via existing statistics should be included within an action plan (paragraph 3.49)."* At the time of this inspection this recommendation had not been addressed in relation to monitoring of detainees coming into police custody. It is important that the PSNI are aware of detainees, reflect all categories and identify any differential outcomes arising.

40 CJI, *Equality and diversity within the criminal justice system: An inspection of the implementation of Section 75(1) of the Northern Ireland Act 1998, September 2018*, available online at: www.cjini.org/TheInspections/Inspection-Reports/2018/July-September/Equality-and-Diversity-within-the-Criminal-Justice.

OPERATIONAL RECOMMENDATION 1

Inspectors therefore recommend that **within six months of the publication of this report, the Police Service of Northern Ireland should address gaps in Section 75 (of the Northern Ireland Act 1998) monitoring of detainees in custody, particularly in relation to community background and sexual orientation.**

2.27 There was a clear understanding by staff of the impact on different demographic groups, particularly on females, children and non-Northern Irish/UK nationals. The focus of the PSNI's training for Custody Sergeants and CDOs on vulnerability emphasised the need to support individuals with different needs and this was backed up by access to services and resources for particular groups.

External scrutiny

2.28 As part of the UK NPM, Independent Custody Visitors from the NIPB's Independent Custody Visiting Scheme made regular visits to custody via three teams working across all the custody suites. The 2018-19 annual report of the scheme reported the following⁴¹:

- there were a total of 524 visits made by Independent Custody Visitors between April 2018 - March 2019;
- 22 visits were not completed (invalid), thus there were 502 valid visits; 88 of the valid visits were classified as unsatisfactory (18%) with 414 classified as satisfactory (83%);
- the South Eastern and Tyrone Fermanagh teams recorded the highest level of satisfaction at 84%; and
- the highest level of unsatisfactory visits was captured by the North West team at 21%.

2.29 CJI met with a group of Custody Visitors who reported the scheme to be received positively by staff within the custody suites. Minor issues were raised and addressed; the only ongoing issue was that of the lift in Lurgan station breaking down regularly. They highlighted the challenges of dealing with detainees with mental health issues and welcomed the introduction of the custody nurses in Musgrave custody suite.

2.30 There was no regular reporting to the NIPB or its Committees by the PSNI on custody matters, apart from the understandable focus on the custody health care programme. There had been some questions asked in the Northern Ireland Assembly and the NIPB about custody.

41 NIPB, *Custody visiting annual report 2018/19*, available online at: www.nipolicingboard.org.uk/sites/nipb/files/publications/annual-custody-visitors-statistics-201819.pdf

EXPECTATION - PARTNERSHIPS

- 2.31 While there was not regular ongoing engagement by District Policing Command with partners in relation to health and social care matters, there were links with other areas of the PSNI for particular work (for example the Public Protection Branch). Strategic contact with UK Border Force and Immigration Enforcement had reduced since the opening of Larne House but custody provision was reported to be well managed when it was required for immigration or border operations. There was limited interaction with the Prison Service, with the exception of the Prisoner Escorting and Court Custody Service in relation to the escorting of detainees from Musgrave custody suite to Laganside Courts.
- 2.32 As highlighted previously, Inspectors believe that there needs to be a renewed focus on the relationship between the PSNI and HSCTs in relation to the approach to ‘Looked After’ children. This may be linked to, but should have a wider scope than, the re-purposing of Woodlands JJC. It may be helpful to establish an annual stakeholder meeting with other partners to identify any area of improvement and consider how shared aims and objectives could support vulnerable adults and children to avoid detention in custody and criminalisation, wherever possible.

CHAPTER 3: **PRE-CUSTODY: FIRST POINT OF CONTACT**

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

EXPECTATION - ASSESSMENT AT FIRST POINT OF CONTACT

- 3.1 There was significant focus on vulnerability in all aspects of police training and there was a focus on diversion for those for whom custody was not necessary or was less appropriate. Diversionary options were well embedded in the PSNI and understood by local Police Officers. Officers reported that they were more able to divert children and young people away from custody than adults; which is understandable given the reported reluctance of health establishments to accept individuals suffering from mental health issues who were under the influence of alcohol and/or drugs.
- 3.2 Flagged information and alerts were available within NicheRMS to call handling, local police and custody staff to identify the vulnerabilities of people who had previously had contact with police. Local police advised that they used voluntary interviews where possible and appropriate, particularly for lower level offences, to avoid bringing people into custody. The PSNI did not collate information on voluntary attenders in order for CJI to verify this. Inspectors were also advised that this was however rarely the case for children who were resident in a children's home, as outlined previously.
- 3.3 A pilot Multi-Agency Triage Team, consisting of local Police Officers working together with mental health practitioners and paramedics had been working in Ards, Down and Lisburn policing areas on Friday and Saturday nights since July 2018⁴². The model was due to run until March 2020. It was reported to be having positive outcomes in supporting individuals suffering with mental health issues and reducing reliance on police, hospital and ambulance resources. The pilot was also helping to divert people who otherwise may come into contact with police away from custody. Challenges continued to exist in other areas about obtaining health and social care support for individuals who had mental health issues or who had consumed alcohol or drugs and whose behaviour often led them to be

42 See www.psnl.police.uk/advice_information/policing-and-mental-health/.

arrested. Support Hubs in some areas provided an early intervention for vulnerable individuals identified predominantly by statutory agencies. This brought together key professionals including blue light services, health and social care staff and the voluntary sector as a cross agency group, to share information and make decisions to improve a person's situation⁴³. CJI welcomes initiatives such as the Triage Team which aim to reduce police resources spent on dealing with people suffering from mental health issues and time spent in emergency departments, with the additional benefits of diverting those people away from custody. CJI would encourage the further roll-out of this initiative, providing the project evaluation demonstrates positive outcomes.

- 3.4 Inspectors saw evidence when reviewing CCTV footage of officers using de-escalation techniques, particularly during the early stages of custody such as booking in or during searches. The booking in process enabled arresting officers to advise the Custody Sergeant about the vulnerabilities and risks to, or posed by, the detainee as well as the circumstances of the arrest. This enabled the Custody Sergeant to commence the risk assessment in an informed manner. Handcuffs were removed routinely on entry to the custody suite and used after that in a risk assessed manner.

43 See www.psnl.police.uk/advice_information/policing-and-mental-health/.

CHAPTER 4: **IN THE CUSTODY SUITE: BOOKING IN, INDIVIDUAL NEEDS AND LEGAL RIGHTS**

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

EXPECTATION - RESPECT

- 4.1 In the vast majority of interactions observed by Inspectors detainees were dealt with courteously during their time in the suite. Inspectors witnessed staff dealing with very difficult and challenging or distressed detainees in a professional, patient and respectful manner, particularly during the booking in process. The layout of most suites, with only one booking in desk in use at any one time, meant that detainees were afforded privacy during their interactions at the custody desk. They were also seen by the health care professional in private. It was more difficult in Musgrave custody suite, with four desks for booking in and two desks for disposal and release, to provide an appropriate level of privacy although Custody Officers considered this when deciding which desks to use.
- 4.2 In the detainee survey 81% of the respondents (34 of 42) said that they were treated 'very well' or 'well' by staff in the custody suite, an increase from 72% in 2015 (39 of 54 who responded to this question). Only two detainees of the 42 in 2019 (5%) reported that they felt victimised by staff which was a decrease from 9% detainees (5 of 55) in 2015. One of these reported being called insulting names by staff and one reported that force was used to remove her jacket, which had drawstrings as part of the hood.
- 4.3 Custody staff made efforts to contact family members or friends on behalf of the detainee when requested. Inspectors saw instances during the booking in process where telephone numbers were obtained from detainees' mobile phones or where several family members were called on the detainee's behalf.

EXPECTATION - MEETING INDIVIDUAL AND DIVERSE NEEDS

- 4.4 A copy of the PACE 12/1 form was available to provide to detainees explaining their legal rights and entitlements while detained in custody. This was available in a variety of languages, however, it was not available in an easy read format or for visually impaired detainees. A copy of PACE (Northern Ireland) was also made available for all detainees. The detainee's rights and entitlements were explained to every detainee through the booking in process. The appropriate adult scheme, 'NIAAS', provided by Mindwise, was in place to protect the interests of children, young people, or vulnerable adults and support, advise and assist them during their period in custody.
- 4.5 Female detainees were searched, strip-searched or requested to change into police-issued clothing only in the presence of two female staff. Many of the custody teams spoken to during the inspection had a female CDO on their shift but if not female officers were brought in from the Local Policing Team or Volume Crime Support Team. In 2016 CJI identified an area for improvement⁴⁴ that "*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 (paragraph 3.3).*" During this inspection it was evidenced that female hygiene packs were available in the custody suite, which staff advised were offered by a female officer on arrival. However only two of seven (29%) females responding to the detainee survey reported that they were offered menstrual protection. Similarly it was only recorded in two of the 23 custody records relating to female detainees in the custody record analysis that a hygiene pack was offered (9%). It is important that the PSNI are able to demonstrate that they are meeting the diverse needs of females and therefore improved recording is likely to be required in this area.
- 4.6 Custody staff were assisted by health care professionals in making decisions about the mental capacity of detainees as well as eliciting information from the detainee themselves. The NIAAS was also helpful in this regard. The enactment of the Mental Capacity Act (Northern Ireland) 2016 will require Custody Officers to make more dynamic assessments of mental capacity and therefore the PSNI should provide training as appropriate in advance of this.
- 4.7 Suites had religious texts and prayer mats available although staff reported that these were rarely requested and again there was limited evidence from the custody records of these being offered. Staff were aware of the considerations to make in regard to transgender detainees and some reported having had transgender detainees held in the suite. In the case file analysis there were two cases involving a detainee who was recorded as being transgender; one in the adult sample and one in the child sample.

44 CJI, *Police custody: The detention of persons in police custody in Northern Ireland, March 2016*, available online at: www.cjini.org/TheInspections/Inspection-Reports/2016/January---March/Police-Custody.

- 4.8 The PSNI had consulted with both the Commissioner for Older Persons in Northern Ireland and the Northern Ireland Commissioner for Children and Young People regarding custody provision. Representatives of both commissioners had visited Musgrave custody suite and been invited by the custody team to make recommendations to improve conditions for the groups of people they represent. As outlined previously both older and younger detainees featured throughout staff training for custody in relation to vulnerabilities and individual needs, including the provision of an appropriate adult and the role of the health care professional. Some concerns were raised about placing children in cells which are in close proximity to adults, but evidence from the case reviews and discussions with custody staff indicated efforts by Custody Sergeants to avoid this where possible, particularly for younger children.
- 4.9 Staff in several suites reported regular detention of non-Northern Irish/UK nationals but this varied depending on location. In one rural suite the Custody Sergeant estimated that around a fifth of detainees were non-Northern Irish/UK nationals. Inspectors saw evidence in the custody records reviewed that detainees were asked if they wanted their Embassy or Consulate to be contacted, as per their right under PACE.
- 4.10 Telephone translation was available at the custody desk to assist with the booking in process and face to face interpretation was able to be arranged for the time of interview. Staff reported the telephone translation service to be quick to respond and that this was available in a range of languages which was generally sufficient for the needs of the detainee population. Arranging face to face interpretation could be more challenging in certain areas, particularly out of hours or for certain languages. As outlined above detainees were able to be provided with a copy of their rights in a variety of languages. Staff were also able to use online translation services to assist with communication with detainees for whom English was not their first language.

EXPECTATION - RISK ASSESSMENTS

- 4.11 In the custody record analysis the average time from the time of arrest to the time of arrival at the custody suite was 35 minutes; in 10 cases this figure was more than one hour but in one of these cases the detainee was taken to hospital after arrest and did not arrive in custody for nine hours and seven minutes (if this case was removed, the average time for the whole sample reduced to 30 minutes). The average time from arrival at the custody suite to authorisation of detention by the Custody Sergeant was 26 minutes; only eight cases took over an hour. Anecdotally, Inspectors had been advised that there were often delays at Musgrave custody suite and recent data had suggested increased waiting times in Antrim. This was not borne out by CJI's analysis which suggested a fairly even spread of times across the eight suites ranging from a minimum average time of 10 minutes to a maximum of 46 minutes.

- 4.12 Inevitably at peak times there was a greater likelihood of increased waiting times but during visits to the suites it was observed that Custody Sergeants and CDOs worked hard to minimise this. Custody staff reported that detainees who indicated particular risks, for example being violent towards arresting officers, requiring medical treatment etc., were escalated to the Custody Sergeant and decisions were made quickly about how best to deal with the situation. The flagged information on NicheRMS, as outlined, highlighted risks and vulnerabilities to the Custody Sergeant before the detainee reached the booking in desk and arresting officers were required to highlight any issues on arrival. Flagged information was added, where appropriate, for detainees who disclosed or displayed self-harm or suicidal thoughts or actions, had medical issues or who were violent on arrest or in custody. Keeping flagged information relevant and up to date and not having so many that the system became unworkable was an ongoing challenge for the PSNI.
- 4.13 The risk assessment process was undertaken using the outlined process on NicheRMS and included questions about injuries, alcohol and drugs, mental and physical health, assistance with reading or writing and any other relevant issues. Custody Sergeants were observed to be proficient in eliciting this information from detainees and Inspectors saw examples of where this was undertaken in a particularly respectful, sensitive and patient manner with detainees who were upset, under the influence of alcohol or drugs or argumentative and aggressive. Detainees were all asked if they wished to see a health care professional and the doctor or nurse was often asked to give advice about the particular needs of the detainee to inform the care plan. In the thematic case analysis Inspectors assessed the observation levels to be appropriate in 33 of 40 (83%) cases.
- 4.14 Several Custody Sergeants highlighted that their biggest concern when it came to the risk presented by detainees was the issue of drug consumption. The difficulties arose in being aware that the detainee had consumed drugs, being unsure what type or quantity of drugs they had consumed or what the effects would be, particularly if they had also consumed alcohol. Custody Sergeants described how they could be talking to a completely lucid detainee one minute who they had no concerns about, yet the next, the detainee could just collapse because of the effects of what they had taken. Many described that they would welcome more training in this area, particularly tailored for detainees.
- 4.15 Care plans were developed for every detainee and Custody Sergeants were required to select the appropriate level of observation, based on the College of Policing's APP for Detention and Custody⁴⁵, as well as the frequency and type of checks. The levels of observation and requirements are set out in the APP are provided in the following box.

45 College of Policing, *Approved Professional Practice Detention and Custody*, August 2018, available online at: www.app.college.police.uk/app-content/detention-and-custody-2/.

College of Policing APP detention and custody levels of observation.

Level 1 general observation

Following full risk assessment, this is the minimum acceptable level of observation required for any detainee. It includes the following actions:

- the detainee is checked at least every hour (the risk assessment is updated where necessary);
- checks are carried out sensitively in order to cause as little intrusion as possible;
- if no reasonable foreseeable risk is identified, staff need not wake a sleeping detainee (checks of the sleeping detainee must, however, continue and if any change in the detainee's condition presents a new risk, the detainee should be roused); and
- if the detainee is awake, staff should communicate with them.

Level 2 intermittent observation

Subject to medical direction, this is the minimum acceptable level for detainees who are under the influence of alcohol or drugs, or whose level of consciousness causes concern. It includes the following actions:

- the detainee is visited and roused at least every 30 minutes;
- physical visits and checks must be carried out – CCTV and other technologies can be used in support of this;
- the detainee is positively communicated with at frequent and irregular intervals; and
- visits to the detainee are conducted in accordance with PACE Code C Annex H.

Level 3 constant observation

If the detainee's risk assessment indicates a heightened level of risk to the detainee (example, self-harm, suicide risk or other significant mental or physical vulnerability) they should be observed at this level. It includes the following actions:

- the detainee is under constant observation and accessible at all times;
- physical checks and visits must be carried out at least every 30 minutes;
- CCTV is constantly monitored (other technologies can also be used);
- any possible ligatures are removed;
- the detainee is positively communicated with at frequent and irregular intervals; and
- review by the Health Care Professional in accordance with the relevant service level agreement.

Level 4 close proximity

Detainees at the highest risk of self-harm should be observed at this level. It must include the following actions:

- the detainee is physically supervised in close proximity to enable immediate physical intervention to take place if necessary;
- CCTV and other technologies do not meet the criteria of close proximity observation but may complement it;
- issues of privacy, dignity and gender are taken into consideration;
- any possible ligatures are removed;
- the detainee is positively communicated with at frequent and irregular intervals; and
- review by the Health Care Professional in accordance the relevant with service level agreement.

- 4.16 Inspectors found confusion within the PSNI about the use and application of Level 1 and Level 2. This appeared to stem from of an Internal Audit report in 2018 and the implementation of its commentary by the PSNI through the custody quality assurance process. Custody staff were inconsistent in their decision making about the need to include rousing at Level 2 and there was confusion about whether detainees on Level 1 could be checked more than once every hour. In the sample of 100 cases reviewed, 94 detainees had a care plan recorded on the custody record which specified the frequency of cell checks, of which just over half (53 of 94; 56%) required the detainees to be checked every 30 minutes but only one record specifically mentioned the need to rouse the detainee.
- 4.17 An example of the challenging nature of risk during the period of custody and the need to keep the care plan under review is highlighted by case example 2.

Case example 2

A 31-year-old man was arrested late at night for criminal damage after breaking a neighbour's window. The risk assessment was completed when he arrived in custody and highlighted that he had a number of mental health problems and had a cut to his head. He admitted he had drunk alcohol recently and the Custody Sergeant noted that he smelt of alcohol, had bloodshot eyes and his speech was slightly slurred. He also needed help with reading and writing and had a learning disability. A flag on NicheRMS, which had been in place since August 2017, noted that he had thoughts of killing himself every day. He was placed on Level 2 observation.

The health care professional was requested to assess his fitness for detention and interview. She visited him in his cell shortly after midnight and confirmed he was fit for detention but not interview and that she would review him at 02:30. She also confirmed he should be roused every 15 minutes for an hour and then every 30 minutes after that until he was reviewed again. This was noted on the care plan as well as instructions to 'ensure the detainee is woken, spoken to and acknowledges the rouse, speaks back'.

Over the next two hours the man removed his clothes and attempted to tie them round his throat on two occasions. He threw his water down the cell and slipped as he was attempting to head-butt the cell door. CDOs spoke to him several times but at one point it was noted that he was too intoxicated to engage. He persistently rang the cell bell and was abusive to staff. He was reviewed by the nurse at 01:45 and his checks were reduced to 30 minutes. By 02:00 his blanket and mattress were returned as it was noted that he appeared to have calmed down. He was provided with a meal and reviewed again by the health care professional. He was asleep when he was checked by 03:27.

Case example 2 (continued)

Initially he was awake and therefore there was no need to rouse him but later when he fell asleep the rousing was inconsistent. The man's level of intoxication required rousing to ensure he remained conscious, as per the instructions of the health care professional. The man should also have been placed on Level 4 constant observations after the first attempt to make a ligature but instead the items from his cell were removed.

- 4.18 The implications of the inconsistent approach to care plans was that the PSNI was not adhering to guidance provided by the College of Policing APP in relation to Level 1 and 2. They were not ensuring that detainees who were intoxicated and should be on Level 2 were roused regularly, but also some detainees were potentially placed on Level 2 who did not need to be. There is a need for Custody Sergeants to keep the care plan and level of observation under review during custody and reduce the level once the need for more intensive checks has passed, with appropriate recording to justify their decision making on the custody record. This is particularly the case for those who arrive when intoxicated under the influence of alcohol or drugs but who become sober during the period of detention; a detainee who has been interviewed should not still be on Level 2 observations when they are leaving the custody suite. In addition, the review of care plans during the custody record analysis highlighted the need for better recording overall in detailing the decision making around the level of observation and frequency of checks (including what input there had been to this from the health care professional), review times by the Custody Officer, health care professional and subsequent decision making around changes to the care plan. Custody Sergeants should be able to evidence active risk management of detainees during their time in custody.

OPERATIONAL RECOMMENDATION 2

Inspectors therefore recommend that **within three months of the publication of this report, the Police Service of Northern Ireland should review its current guidance on care plans and reinforce, through guidance issued and the quality assurance process, the need for sound decision making and better recording of care plans on the custody record that are in accordance with the College of Policing's Authorised Professional Practice for Detention and Custody.**

- 4.19 Handovers took place between each shift with Custody Sergeants and CDOs holding separate handovers. It would be a more effective process if all staff conducted this handover together, which will become more important when custody nurses become an embedded part of the custody team in each suite and can contribute to the handovers in relation to the physical and mental health of the detainees.

EXPECTATION - INDIVIDUAL LEGAL RIGHTS

- 4.20 The custody record analysis examined the decision making around detention and the time spent by the detainee in custody. As outlined there were three cases in the total sample (one child in the sample of 100 adult and child cases and two in the additional sample of 40 children) where detention was not authorised, that is that the Custody Sergeant declined to accept the individual into custody. In other cases there was evidence of Custody Sergeants asking arresting officers to justify the need for detention and why other options were not possible.
- 4.21 In the 99 cases where detention was authorised the average time from arrival to decision as to how the detainee would be dealt with was 8 hours and 54 minutes; seven of these cases were dealt with in under one hour and only three detainees were in custody for more than 24 hours. A total of 50% of detainees (50) were held overnight. Inspectors were advised that the involvement of Case Process Teams in Belfast and Volume Crime Support Teams elsewhere meant that custody cases were able to be dealt with quicker, as these officers received a handover pack from the Local Policing Team and were then dedicated to dealing with the investigation. These teams also assisted in dealing with bail returns which freed up time for custody staff.
- 4.22 Digital recording equipment had been installed in the interview rooms in every suite since the last inspection and this was reported to work well and save time, resources and storage required for tape recording. The exception to this was for detainees being interviewed in relation to terrorist offences as the Terrorism (Northern Ireland) Act 2006 legislation did not provide for digital recording. Inspectors were advised that this was intended to be addressed when the legislation was next updated.
- 4.23 Staff and solicitors reported positive, professional working relationships which assisted in working together in a constructive way for the benefit of the detainees. Local solicitors were generally well known to the custody staff and were reported to appropriately challenge the Custody Sergeant's decision making, with both demonstrating good communication well in advance of key decisions around continued custody.
- 4.24 There was evidence from the case file reviews and staff spoken to that cases involving children were prioritised and released from custody as soon as possible. Inspectors compared the average total time spent in custody from custody records reviewed (48 children and 89 adults). This showed the average time spent in custody was 7 hours, 10 minutes for children versus 11 hours, 32 minutes for adults.
- 4.25 Detainees were offered a copy of their rights and entitlements under PACE and this was available in a variety of languages. There was no 'easy read' version of PACE for children or for adults who had limited reading ability but as part of the booking

in process, the Custody Sergeant was required to advise the detainee of their rights and record whether they wished to avail of the opportunity to speak to a solicitor, have someone informed of their arrest, see the health care professional etc.

- 4.26 In Belfast there was a duty solicitor list and elsewhere lists of local solicitors firms and detainees were able to use one of these solicitors or request one that they knew. Initial consultation was usually by telephone at the booking in desk and then solicitors attended to consult with their client prior to interview.
- 4.27 Solicitor consultation rooms, which were not covered by audio or video recording, were available in every suite and detainees were able to talk to their legal representative in private. Inspectors saw examples in the custody record where detainees had initially declined a solicitor, with the reasons recorded, but then later changed their mind and this was arranged for them. Solicitors were given a hard copy of the custody record on arrival at the suite and were able to ask questions of the Custody Officers. There were no issues raised with Inspectors about decisions made regarding fitness for detention or interview.
- 4.28 Police custody suites were much less frequently used for immigration detainees since the opening of Larne House Short-Term Holding Facility and where it was used by Home Office Immigration Enforcement, this was usually undertaken in a planned way with effective relationships reported between the two organisations. Similarly use of custody by Her Majesty's Revenue and Customs was rare but well organised.
- 4.29 The PSNI had recently changed their policy on the taking of deoxyribonucleic acid (DNA) samples so that a single sample would be taken for both identification and investigation purposes, but CDOs were well aware of this and had been trained to evidential standard. Posters existed on the walls of the processing room regarding the taking, disposal and retention of DNA but there was nothing specific on the custody record to indicate that detainees were given details of the policy verbally.
- 4.30 PACE⁴⁶ sets out the requirement for the detainee's detention to be reviewed during the period of time in custody no later than six hours after detention was first authorised, then no later than nine hours after the first and then, subsequent reviews of not more than nine hour intervals. PACE Code C⁴⁷ sets out that the first and second reviews should be conducted by a police Inspector, that the third review must be conducted by an officer of Superintendent rank or above who may extend the period of detention for a period of 12 hours and any further extension thereafter must be authorised by a Magistrates' Court.

46 The Police and Criminal Evidence (NI) Order 1989, available online at: www.legislation.gov.uk/nisi/1989/1341/contents.

47 Department of Justice, *PACE Code C: detention, treatment and questioning of persons by police officers*, June 2015, available online at: www.justice-ni.gov.uk/publications/pace-code-c-detention-treatment-and-questioning-persons-by-police-officers.

- 4.31 Of the 100 custody records analysed by Inspectors the majority of reviews were conducted by an Inspector, with only one review in the sample completed by a Superintendent and no Magistrates' Court extensions required. A total of 58% (58) detainees were detained for over six hours and therefore required at least one review by an Inspector, although one of these detainees was charged after 6 hours and 24 minutes and left custody before a review was completed. Of the 56 records examined by Inspectors where a first review was completed in 70% (39 detainees) this was completed by the Inspector as a 'sleeping review' (that is where the detainee was asleep and the review was done in consultation with the Custody Sergeant but without representations from the detainee). In 14% of cases (8) the review was conducted in person, in 7% (4) by phone, in 5% (3) the detainee was in hospital and in the final 4% (2) a review for breach of bail was completed. In 96% of the cases involving a first review these were completed within the time provisions specified by PACE.
- 4.32 Of the 19 second reviews required 53% (10) were completed as a sleeping review with 26% (5) in person and in 11% (2), the Inspector was unable to seek representations from the detainee due to other activity in the custody suite. A total of 95% (18 of 19) of second reviews were completed within time. There was no use of video conferencing to complete reviews, as an alternative to the use of telephone reviews (albeit that there were few of these completed) but this may be a future opportunity. It was reported to Inspectors that Superintendents' reviews were well planned for and always done in person, as required by PACE. The ability to undertake Superintendent reviews by Live Link was being considered by the DoJ with a targeted consultation underway at the time of writing.
- 4.33 It was unclear to Inspectors why such a large proportion of reviews were conducted as a sleeping review. Given that a significant number of detainees will be arrested and brought to custody late at night or in the early hours of the morning, it is understandable that detainees may be in the middle of a period of rest six hours after their arrival. However Inspectors saw examples in the custody records of occasions where a sleeping review was conducted very close to the time where a detainee had just been given a meal or were recorded as being awake during a cell check. In addition, whilst the standard wording used in the custody record for the Inspector's review stated that the detainee should be advised that a review was completed whilst they were asleep and reminded of their rights, there were virtually no entries on the custody record to record that this had been done.
- Area for improvement: the Police Service of Northern Ireland should undertake further analysis regarding the use of sleeping reviews by Custody Inspectors and address any issues arising.**

EXPECTATION - ACCESS TO SWIFT JUSTICE

4.34 Table 6 shows the type of disposals used for all the cases in the two sets of custody record analysis as well as the breakdown for children and adults. This shows a greater use of charge or summary report to the Public Prosecution Service for Northern Ireland (PPS) for adults than children. For children however the greater use of release to report to the PPS is likely to be as a result of the focus on getting them released from custody more quickly as well as the nature of the offences children commit.

Table 6: Recorded disposals in custody record analysis*

Disposal	Overall		Children		Adults	
	No.	%	No.	%	No.	%
Charged, refused bail	16	12%	2	4%	14	16%
Charged and released to attend court	21	16%	0	0%	21	24%
Police bail pending further investigation	46	34%	17	38%	29	33%
Released with view to report to PPS	36	27%	22	49%	14	16%
Released unconditionally	3	2%	0	0%	3	3%
Transferred to court - breach of bail	5	4%	2	4%	3	3%
Transferred to JJC	1	1%	1	2%	0	0%
Transferred to prison	1	1%	0	0%	1	1%
Community resolution	4	3%	1	2%	3	3%
Other	1	1%	0	0%	1	1%
Total	134		45		89	
Detention not authorised	3		3		0	

* Where totals add to more than 100% this is due to rounding issues.

4.35 The PSNI had recently reviewed bail and the oversight of it, in order to improve consistency and ensure the appropriate use of bail and conditions. The Service Procedure had been reviewed and re-issued in March 2019⁴⁸. This had included guidance specifying which Inspector roles should perform the function of reviewing officer to provide oversight and review the use of bail in various types of cases. The PSNI emphasised the need for a Bail Act to address these issues across the system but had completed this work in its absence.

48 PSNI, *Service Instruction SI0219: Bail, March 2019*, available online: www.psnipolice.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/bail-070319.pdf

- 4.36 As outlined before the use of Case Processing and Volume Crime Support Teams was reported to have had a positive effect on dealing with cases where the detainee was in custody. A Bail Team had been set up in Belfast where a Custody Sergeant performed the role of bail manager, ensuring investigations were progressing where the defendant was on police bail, and dealt with all bail returns at a specific location. This was reported to work well, ensuring a focus on those bailed and taking pressure off Custody Sergeants to deal with the management of others currently in custody. Bail conditions appeared to be proportionate to risk and there was evidence they were discussed with the detainee and their legal representative and that Custody Sergeants felt confident to challenge Investigating Officers if they did not agree with the bail conditions proposed. The standard time set for bail was 28 days and there were no examples seen of bail not being appropriately timed. There were examples of good communication between police and legal representatives around bail timings and arrangements.
- 4.37 In Musgrave custody suite a form had been developed where Investigating Officers were required to email through disposal details for the case including proposed bail conditions prior to attending the suite for disposal. Although officers understood that this aimed to ensure consistency of approach and speed up the disposal process, feedback received suggested that it had in fact caused delays and added unnecessary bureaucracy. Inspectors welcome attempts to improve the effectiveness of the disposal process but would encourage the PSNI to consult with Investigating Officers when reviewing the implementation of this process to find ways to address their concerns.
- 4.38 The relationship with Woodlands JJC was constructive with Custody Sergeants having a good knowledge of the processes surrounding use of Woodlands JJC for bail, including cut off times in the evening. As outlined in Table 6 there were only two cases in the custody record analysis where a child was charged and refused bail and one case where a child was transferred to Woodlands JJC. In one of these cases a 13-year-old child arrested and taken to Musgrave custody suite was transferred to Woodlands JJC overnight. In the other a 15-year-old girl was arrested who was from outside the jurisdiction and a surety was not available. She was therefore held in Banbridge custody suite until court the following day. Finally one child was transferred to Woodlands JJC for breaching their bail conditions.
- 4.39 In this inspection there was no evidence of children being detained inappropriately for long periods of time due to an inability to access a bail address. However as outlined previously offences committed in a children's home did tend to result in overnight detention in the custody suite because the children's home were unable to provide a social worker to act as an appropriate adult out of hours or because the offence was committed against a member of staff in the home. These children were then released back into the care of social services, usually back to the children's home, the following morning.

Of all the custody records analysed where the detainee was a child (48 in total) there were 10 cases where the detainee was a 'Looked After' child (21%). Comparisons of the time spent in the custody suites for both groups showed that 'Looked After' children spent, on average longer in custody than those who were in the care of their parents or guardians (8 hours 58 minutes versus 6 hours 31 minutes). 'Looked After' children appear to be disproportionately affected by their inability to access an appropriate adult and appropriate bail accommodation.

EXPECTATION - COMPLAINTS

- 4.40 Posters were located in custody suites about the role of the Office of the Police Ombudsman for Northern Ireland (OPONI). Inspectors observed a detainee in one custody suite, who was unhappy with her treatment, being asked if she wished to make a complaint to the Custody Sergeant or via her solicitor and then being given information about the OPONI. In the detainee survey half of those spoken to (21 of 42, 50%) responded 'yes' when asked if they were told how to make a complaint about their treatment, an increase from 35% (19 of 55) in 2015.
- 4.41 The OPONI recorded and reported on allegations regarding 'conduct in custody suite', as a Failure in Duty allegation category. This included incidents where the complainant was denied access to legal advice or medical attention while they were detained in custody. In addition it covered instances where it was alleged the officer did not inform the detained person of their rights and entitlements, or the officer did not keep accurate custody records. The Annual Statistical Bulletin of the Police Ombudsman for Northern Ireland 2017-18⁴⁹ reports a consistent downward trend in relation to Failure in Duty allegations regarding conduct in a custody suite. Figures show 119 allegations made in 2017-18, a reduction from 180 made in 2013-14.
- 4.42 CJI Inspectors met with a representative of the OPONI and were provided with statistics between April 2017 and September 2019 for complaints and investigations relating to police custody. The following box provides a summary of the information provided.

49 Police Ombudsman for Northern Ireland, *Annual Statistical Bulletin of the Police Ombudsman for Northern Ireland 2017-18, June 2018*, available online at: <https://www.policeombudsman.org/getmedia/37e06a5e-28e1-43e1-93b7-d6f023471344/Annual-Statistical-Bulletin-2017-18.pdf>

Statistics on complaints w to the OPONI about treatment in custody.

There were 107 public complaints, Section 55^a matters or notifications received about treatment in custody between 1 April 2017 and 30 September 2019^b.

Of the 107 investigations; one is a Chief Constable referral about a death in custody, three are Police Ombudsman Call-Ins; two of these are about a death following custody and the other one is about an officer's behaviour towards a vulnerable person. Ten were notifications from police which did not result in either a complaint being made by a member of the public nor did they reach the threshold for a Chief Constable referral or a Police Ombudsman Call-In.

The remaining 92 were complaints made by members of the public. The most commonly made allegations within these complaints were about oppressive behaviour (46%). Most of these allegations are about excessive force/non-serious assaults, followed by allegations about failure in duty (32%); these are mainly about failures relating to how they were treated while in custody.

Profile of Complainant

Around four out of five (84%) of these public complaints were made by males. More than half (57%) were made by adults aged between 25 to 44 years old. Fewer than 10% were made by persons aged under 18.

Outcomes

The Chief Constable referral and the three Police Ombudsman's Call-Ins are still under investigation. The 10 notifications received from the police have been closed without an investigation being conducted. Of the 92 public complaints, 82 have been closed; 41% of these complaints were closed as not substantiated and 34% were closed as the complainant did not fully engage with the service. Eight of the complaints (10%) were either all or partially substantiated; in which six resulted in a recommendation for a discipline or a performance action.

a A Section 55 matter is where a matter has been referred to the Office for an independent investigation or where the Office has decided to investigate a matter as it is in the public interest to do so.

b This may be an underestimation due to how the information is recorded.

- 4.43 The PSNI provided information to show that in the three years between 2016 and 2019 there had been 10 deaths of detainees within 48 hours of having had police contact. One of these cases had occurred in 2018-19. These cases were referred to, and investigated by, the OPONI. Custody staff were acutely aware of the ongoing responsibility to ensure the safety of those who had been detained in custody during the custody process and following their release.

4.44 In January 2020 the inquest concluded into the death of John Brady, in Strand Road custody suite in 2009. The Coroner found Mr Brady was arrested in a proportionate fashion, properly assessed as being of low risk and treated in accordance with his assessment, but stated *“Certain steps were taken to protect Mr Brady while he was in custody but there was a critical failure to supervise him properly when he was placed into a Consultation Room after the decision to charge was taken.”*⁵⁰ As CJI reported in 2016, since the death of Mr Brady the PSNI had introduced a locking system to consultation rooms in all custody suites whereby solicitors could not leave the room without requesting that custody staff unlocked the door, thereby alerting them to the fact the detainee needed to be supervised or escorted back to their cell. This system remained in place at the time of this inspection. The Coroner also raised concerns about the ‘unhelpful layout’ of Strand Road Custody Suite which will, in due course, be addressed when the new build suite at the Waterside Station becomes operational.

50 McCrisken, J, Coroner for Northern Ireland, *Inquest into the death of John Hugh Brady: Factual findings*, 29 January 2020. Provided to CJI by Legacy and Coronial Services, Northern Ireland Courts and Tribunals Service.

CHAPTER 5: **IN THE CUSTODY CELL, SAFEGUARDING AND HEALTH CARE**

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody.

EXPECTATION - PHYSICAL ENVIRONMENT

- 5.1 The PSNI had 11 custody suites in its estate at the time of the inspection, of which eight were operational during the period of suite visits. During the inspection the PSNI were undertaking a significant programme of work to upgrade the medical rooms to National Health Service (NHS) standard which was ongoing during the period of the fieldwork in preparation for the move to custody nurse-led provision. This was being delivered in a managed way with each suite closed for six to eight weeks and detainees diverted to an alternative suite.
- 5.2 The PSNI also undertook a rolling programme of routine maintenance every quarter, which required each suite to be closed for one or two days. Practice fire evacuations were also planned to be completed twice a year during these periods of closure using Police Officers based in the station as 'detainees'. Fire packs, which included flexible handcuffs, were available in the suites. Custody staff reported that more urgent maintenance issues were dealt with promptly by the Estates Services Business Unit without the need for cell or suite closures.
- 5.3 Longer term the PSNI had plans in place to further rationalise the custody estate and close older and unsuitable suites. This plan included new-build suites with greater capacity located in the Waterside Station in Derry/Londonderry to serve the Foyle area (thereby replacing the suite at Strand Road) and in Mahon Road Station, Portadown (to replace the suites in Banbridge, Lurgan and Dungannon). The building of the Waterside suite had commenced during the fieldwork for this inspection and planning permission for the Mahon Road suite was about to be applied for. The PSNI's Head of Estates was part of the national groups regarding custody suite design and was linked in to national developments, including research ongoing as to how the aesthetics of cells could be improved to reduce the stress experienced by detainees.
- 5.4 Several of the suites mentioned above were older and lacking in modern design with, in many cases rooms and areas which were too small and cramped, a lack of in-cell sanitation and limited storage facilities. Despite this, overall the suites and cells within them were in a good state of repair. There was no graffiti or ligature points evident in the cells inspected (albeit that three of the 42 detainees

surveyed, 7%, reported that there was graffiti in their cell) and detainees ratings of cell conditions had improved since 2015⁵¹. New cell doors had been introduced in some suites during refurbishment which were unlocked by electronic fob rather than metal keys, thus increasing safety and providing an audit trail of entries to the cell. Every cell had a cell bell and 90% of detainees surveyed (38 of 42) said that the staff had explained the correct use of the cell bell to them; an increase from 62% (34 of 55) from the 2015 survey. In one custody record in the sample it was noted that a call bell was switched off for five minutes while the detainee calmed down. Cell bells should not be able to be permanently muted. All suites had CCTV with cameras covering cells, corridors, the booking in desk, vehicle docks and interview rooms.

- 5.5 CDOs were responsible for cell 'refreshes' if a detainee had only spent a short period of time in a cell and it did not require cleaning before further use (for example, if they had not slept in it). The cleaning of the suites was undertaken by a contractor under a managed service contract and the custody suite was cleaned on a daily basis. Deep cleaning took place after the cell was contaminated by bodily fluids or if used by a detainee with a transmittable disease.
- 5.6 Most suites had checking systems for automated external defibrillator (AED) and oxygen cylinders to ensure equipment required in an emergency was functioning properly (see 'patient care').

EXPECTATION - SAFETY: USE OF FORCE

- 5.7 The CJI 2016 Police Custody inspection report⁵² highlighted that the PSNI was not following the College of Policing Detention and Custody APP guidance around collating data on the use of force in the custody suite electronically in a way that allowed it to be readily retrieved and analysed. The report therefore noted as an area for improvement that "*The PSNI should follow College of Policing guidance in respect of collating use of force data*" (paragraph 3.34). Since then the PSNI had established a system whereby individual use of force records were completed and compiled on a monthly basis to enable analysis to be conducted. This provided equality monitoring information including gender, age and ethnicity. The data enabled the District Policing Command Custody team to review patterns and trends in respect of use of force, for example relating to different suites or particular members of staff. It was an ongoing challenge for the PSNI to ensure forms were submitted appropriately in relation to every use of force. A quality assurance process was about to begin at the time of the inspection, whereby CCTV footage of use of force would be dip sampled by the District Policing Command Custody Team to identify areas of good practice or where further training or development was required.

51 More detainees reported cell conditions to be 'good' in the 2019 survey compared to the 2015 survey in the four criteria of cleanliness (69% vs 60%), ventilation/air quality (64% vs 47%), temperature (55% vs 45%) and lighting (81% vs 58%).

52 CJI, *Police Custody: The detention of persons in police custody in Northern Ireland, March 2016*, available online at: www.cjini.org/TheInspections/Inspection-Reports/2016/January---March/Police-Custody.

5.8 Data was provided by the PSNI for the purposes of this inspection in relation to all recorded use of force during October 2019⁵³ and for the most significant uses of force in the previous three years. The data for October 2019 is outlined in Table 7. This data shows that the majority of use of force reports were submitted in relation to the use of physical restraint then take downs (where physical force is used to push the suspect to the ground for restraint purposes) and handcuffs. There was no evidence or reports of use of a Conductive Energy Device ('Taser') or incapacitant spray in custody either in this data or in the inspection fieldwork itself.

Table 7: Recorded use of force in custody during October 2019

Type of force	Total recorded uses	
Unarmed Physical Tactics	Baton Drawn (not used)	2
	Blocks/Strikes	6
	Take Downs	38
	Pressure Points	7
	Physical Restraints	102
	Others or Improvised	7
Handcuffing/ Limb Restraints	Handcuffs	30
	Limb Restraints	6
Total	198	
Number of detainee subject to use of force in October 2019	83	
Total number of detainees in October 2019	2,212	
Percentage of detainees subject to use of force in October 2019	4%	

5.9 Similarly figures for 2018-19 indicated no use of Emergency Restraint Belts, spit-guards or Taser with only one recorded use of incapacitant spray and one use of a baton. Limb restraints were used 126 times during the year. Chapter 4 of the PSNI Conflict Management Manual⁵⁴ stated that 2-chlorobenzalmalononitrile a cyanocarbon ('CS') Spray should not be routinely carried within the confines of a custody suite. *"The use of CS Spray within the confines of a custody suite must only be in the most exceptional circumstances. CS Spray should not be used in an enclosed area or upon a subject who is restrained or handcuffed, unless the nature of the risk to the officer or other person is such that this cannot be avoided."*

53 This is data collated for operational purposes and therefore not official statistics.

54 PSNI, *PSNI Manual of Policy, Procedure and Guidance on Conflict Management: Chapter 4: CS incapacitant spray*, April 2013, available online at: www.psni.police.uk/globalassets/advice--information/our-publications/conflict-management-manual/chapter_4_-_cs_incapacitant_spray.pdf.

- 5.10 At the time of the inspection the PSNI had not adopted the use of ‘spit-guards’⁵⁵ although a business case had been submitted to the Service Executive Team about their introduction across the PSNI, including for use in custody. The Health and Safety Branch had been involved in work to establish the extent of the problem of spitting as a health and safety issue for staff and had been involved in the production of the business case. HMICFRS highlighted in their 2017 national overview of police legitimacy⁵⁶ that 19 forces in England and Wales had spit-guards in use as of January 2017 and that policies on their use varied considerably across forces. They noted “forces and the public would benefit from further national consideration of the efficacy, safety and legitimacy of spit-guards”. CJI has been involved in discussions across the UK within the NPM about the use of spit-guards, to date, by various forces in England, Wales and Scotland. The NPM would also have concerns about the lack of governance, approved models/suppliers, national guidance and evaluation about the use of spit-guards and would therefore urge the PSNI to balance this against the health and safety issues for staff.
- 5.11 Custody Sergeants and CDOs received training specific to their role, via the Personal Safety Programme, which included de-escalation, approved techniques and use of equipment. This was provided during initial training and then regular refresher training. Staff spoken to could describe risks in relation to use of force and the benefit of dealing with detainees sensitively and respectfully in de-escalating situations. The fact that CDOs were police staff rather than Police Officers was cited as being of benefit in dealing with detainees who disliked the police. As noted previously a recording form was completed after any use of force in the custody suite and these were sent for collation by the PSNI Statistics Branch. Use of force was also recorded in the individual custody record, as well as any flagged information against the detainee record for example, in relation to violence against staff or concealment of weapons or drugs.
- 5.12 As part of the thematic case reviews for this inspection CJI Inspectors reviewed 10 cases where force had been used during the period of detention by a detailed examination of the custody record. Inspectors then reviewed the CCTV footage for those 10 cases as well as an additional case from the thematic review of cases involving detainees with mental health issues and two cases from the custody record analysis (13 cases in total). Two of these cases had not had a use of force form submitted. In the main, use of force appeared to be proportionate and for an appropriate period of time, with a couple of excellent examples of de-escalation being used. In one incident in particular, a CDO was confronted with a detainee with an improvised weapon and managed to de-escalate the situation; this example is summarised in case example 3. CJI referred two cases back to the PSNI to review where Inspectors felt that the technique used was poor.

55 In March 2020 the PSNI commenced the use of spit and bite guards in response to the threats posed by detainees who were suspected of having Covid-19.

56 HMICFRS, *PEEL Legitimacy 2017: A national overview, December 2017*, available online at: www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-police-legitimacy-2017-1.pdf

Case example 3

Police attended a report of a male lying on a garage roof unconscious. When the officer went onto the roof the man pushed him and was arrested for possession of an offensive weapon and assault of a Police Officer. The custody record indicated that the man was under the influence of drugs. Several Police Officers were involved in escorting the man to custody. The use of 'soft force' (that is, force that doesn't require use of any equipment such as holding a detainee's arm) was recorded on the custody record when the man was booked in and handcuffs were used on him. Force was then used to conduct a strip search due to the man not co-operating.

As the man was being charged he could be seen on the CCTV footage suddenly grabbing a screwdriver and then making significant threats with the screwdriver to a female CDO. The man then jumped into the custody office and threatened everyone around him. The officers rushed in but were held back by the CDO. A Chief Inspector, who came down to the suite after the panic alarm was sounded, calmed the situation by talking the man down. The female CDO stood her ground and also tried to talk the detainee down. More officers arrived with shields but by that stage it had all been de-escalated. The Chief Inspector and CDO talked at length with the man in the exercise yard during which he became tearful.

This was an excellent demonstration of how de-escalation was used to calm an extremely volatile situation with significant threat of harm.

5.13 Much of the CCTV footage watched of individual cells had no audio recording available; either because the CCTV in the cell did not have audio recording at all or because this was only activated for a period of time, for example when the cell buzzer was pressed. This meant it was difficult to establish in some cases what was said by the detainee and/or custody staff as well as how it was said, to give an indication of how the situation which led to the use of force escalated. For the PSNI to make best use of its dip sampling processes it would be important to address this with Estates Branch at an early stage. **Area for improvement: in order to improve the quality assurance process for use of force the Police Service of Northern Ireland should:**

- **establish whether it is possible to improve the coverage of audio recording in existing custody cells; and**
- **ensure audio recording which records every interaction between detainees and staff in the cell is included in the specification for new build suites.**

- 5.14 The provision of suitable equipment provided to custody staff for cell interventions (where CDOs needed to enter the cell but the detainee was behaving in a violent manner and there was a risk to life) was cited as an unresolved challenge. As the fieldwork for this inspection concluded the PSNI were continuing to engage with suppliers to identify alternatives.
- 5.15 Strip-searching required authorisation from the Custody Sergeant and was conducted by custody staff of the same gender as the detainee. In Musgrave custody suite the search room had an area in which the CCTV camera was pixelated to ensure privacy. In other suites there was no designated search room and therefore such searches were conducted in cells or in processing rooms. The PSNI's self-assessment data showed that a total of 1,045 detainees (4% of all detainees) were strip-searched during 2018-19, 851 were male and 194 female. Strip-searches were conducted on 58 children aged under 18 (3% of all child detainees).

EXPECTATION - DETAINEE CARE

- 5.16 The custody suites had supplies of a range of ambient meals, suitable for a variety of dietary requirements as well as breakfast bars, hot drinks and water. Where detainees were held for a longer period of time solicitors were permitted to bring in food in sealed packaging. Of the 42 individuals who responded to the detainee survey 86% (36) confirmed they had been offered something to eat and 88% (37) something to drink. The thematic case audit identified 12 of the 40 custody records (30%) where there was no evidence that the detainee was offered food and drink regularly. This may well be a recording issue as Inspectors did not encounter significant complaints from detainees.
- 5.17 Just under a quarter of detainees (10 of 42; 24%) responding to the survey confirmed that they had been offered a shower in custody. In the custody record analysis it was recorded that just 8% of all detainees for whom detention was authorised (8 of 99) were offered a shower but for those who were due to appear in court after being released this increased to a quarter (4 of 16; 25%) and for those held over 24 hours this rose to a third (3 of 9; 33%). The thematic case audit confirmed this with evidence on the custody record that 10 of the 40 detainees (25%) had been offered a shower. Wash packs and towels were available in the suites. Alternative clothing and footwear were available for those for whom the risk assessment raised concerns about their clothing (for example because of drawstrings round tops or trousers) or who needed clean clothing. In the thematic case audit 60% (24 of 40) of the records showed that detainees were offered alternative clothing.

5.18 None of the detainees spoken to and none of the thematic case audits showed evidence that outdoor exercise was offered and it was confirmed by custody staff that outdoor exercise yards, where available, were rarely used. Given the relatively short stay in custody for most detainees Inspectors would not have significant concerns about this, but would suggest that the PSNI assure themselves, via the quality assurance process, that this opportunity is at least offered to those who are held in custody for longer periods of time. Reading materials were available in suites, including religious texts, and Inspectors saw some detainees being offered a book or newspaper. Again there was limited evidence of this from the detainee survey or records with only 12% of detainees (5 of 42) reporting that they had been offered something to read and evidence in only two custody records (5%) in the thematic case audits of reading material being offered.

5.19 There was no evidence from the custody records reviewed that children or vulnerable detainees received visits by family members and/or appropriate agencies, other than those provided on a statutory basis (for example social workers and appropriate adults). However as highlighted previously there was evidence of parents or social workers being allowed to stay with children in custody, therefore avoiding the need for them to be placed in a cell.

Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk).

EXPECTATION - SAFEGUARDING

5.20 Custody staff were clearly aware of their responsibilities regarding protecting the rights of children and vulnerable adults and of the need to provide an appropriate adult for these detainees, whether through contacting parents or guardians, social workers or through the Mindwise NIAAS. Staff reported difficulties in contacting social services out of hours during evenings and weekends which appeared to be a consistent problem across the five HSCTs.

5.21 The PSNI had Service Procedures in respect of both child protection and adult safeguarding which provided relevant information and links to the DoH and Safeguarding Board/Northern Ireland Adult Safeguarding Partnership policies and procedures as appropriate. Both of these policies focused more on the individual as a victim rather than as a potential offender and were limited in respect of detail around how those arrested should be dealt with.

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- 5.22 CJI's recently published inspection of Child Sexual Exploitation (CSE)⁵⁷ highlighted the need for improved policy guidance in the area of child sexual abuse recommending "All agencies should review and update procedures applicable to tackling child sexual abuse including CSE and ensure alignment with child protection policy and procedures....In particular....The PSNI develop a CSE operating procedure that is grounded within child protection, and ensure that all other related PSNI procedures and instructions are cross referenced and aligned." The PSNI's Action Plan⁵⁸ in response to the report confirmed that this work would be undertaken stating "A separate service instruction on CSE will be developed and issued to the Police Service. This will be cross referenced with an updated Child Protection Service Instruction, Missing Person Service Instruction and the Runaway and Missing From Care Protocol." Inspectors believe that there is benefit in including the Custody Service Procedure in this work in order to ensure that there is a clearer link between the detention of children and young people in custody and the PSNI's child protection responsibilities. The PSNI's approach to child protection will be the subject of a future inspection by CJI.
- 5.23 The PSNI's Public Protection Branch formed the link between custody and social services in respect of child protection or adult safeguarding concerns. The Central Referral Unit in the Public Protection Branch received and dealt with all referrals from within the PSNI as well as from social services, health care professionals, education, concerned members of the public etc. Custody staff referred to contacting the Public Protection Branch if they needed advice or guidance about how to deal with a safeguarding issue.
- 5.24 It was evident from both discussions with custody staff and from the custody records reviewed that parents, guardians or, for children in care, social services, were contacted as soon as a child was detained. This was often completed prior to the detainee arriving at the custody suite by the arresting officer. In some cases it was evident from the custody records that staff had made numerous attempts to contact those responsible for the child's welfare.

Northern Ireland Appropriate Adult Scheme

- 5.25 Mindwise had delivered the NIAAS since 2010 and was, at the time of the fieldwork in year three of a four year contract. The Scheme was therefore well established and well known to custody staff. The Scheme Manager presented a session on the role of the NIAAS during the custody training courses. Custody staff were positive about the role of the appropriate adults and their support of the detainees. In some rural areas it was commented that there could be occasional delays when requesting an appropriate adult, but in most suites they referred to their 'regular' appropriate adults who were quick to respond.

57 CJI, *Child Sexual Exploitation in Northern Ireland: An inspection of the criminal justice system's response, June 2020*, available online at: <http://www.cjini.org/TheInspections/Inspection-Reports/2020/April-June/Child-Sexual-Exploitation-in-Northern-Ireland>.

58 Available on CJI's website at www.cjini.org/getattachment/7136a74d-9f04-41dd-886f-19160dc26f48/PSNI-Child-Sexual-Exploitation-Inspection-Action-Plan.aspx

- 5.26 In 2017-18 Mindwise responded to 3,555 requests to attend PSNI stations during the reporting year, a significant increase from the period in which CJI reported on in its last police custody report when they had received 2,185 requests during 2013-14⁵⁹. In the NIAAS Annual Report 2017-18⁶⁰ it was reported that unplanned calls (where an appropriate adult is requested without any prior notice) occurred on 2,216 occasions being 60% of all calls. Despite this when both planned arrivals and unplanned arrivals requests to attend were counted collectively, an appropriate adult arrived when they were expected to arrive in 96.8% of all requests. A representative of the Mindwise scheme was based in Musgrave custody suite from 9am to 5pm, Monday to Friday, which ensured a quick response to deal with the significant number of requests for an appropriate adult (Musgrave custody suite accounted for 54%, 1,909, of the total 3,555 attendances by the NIAAS in 2017-18⁶¹).
- 5.27 The ability to contact and secure attendance of a social worker, if the detainee was a child in care, was much more of a challenge with custody staff reporting that out of hours there was little chance of staff being available. Mindwise occasionally performed the appropriate adult role for 'Looked After' children, if there was an urgent need or the welfare of the child was in danger of being affected, but this was not part of the contract and they were understandably reluctant to provide this service on a routine basis.
- 5.28 Parents were utilised in the role of appropriate adult where they could be contacted by the arresting officer or custody staff and this was evident from the case files, especially in cases where the child was dealt with and released quickly. In many cases where the NIAAS was required, it was because the parent or guardian was unable or unwilling to attend the station. In some cases the Custody Sergeants were exercising suitable levels of caution when deciding on the appropriateness of the appropriate adult, for example if the parent or guardian had consumed alcohol.
- 5.29 The NIAAS was one of a number of services delivered by the charity Mindwise, and as such was subject to their wider corporate governance, accountability and risk management processes and procedures. Staff were able to avail of training across a range of issues relating to vulnerability and mental health, including safeguarding. The DoJ was the sponsoring body and accountability meetings were held on a quarterly basis to report on 22 Key Performance Indicators. The Annual Report provided analysis of a range of metrics including data on requests, attendance times and locations and biographical and need information on detainees (for example age, gender, vulnerabilities).

59 *Police Custody: The detention of persons in police custody in Northern Ireland, March 2016, available online at: www.cjini.org/TheInspections/Inspection-Reports/2016/January---March/Police-Custody.*

60 *Mindwise, Northern Ireland Appropriate Adult Scheme annual report 2017-2018, 2018.*

61 *Mindwise, Northern Ireland Appropriate Adult Scheme annual report 2017-2018, 2018.*

5.30 In the custody record the Custody Sergeant was routinely required to record the time the request was made for the appropriate adult to attend, what time they arrived, their name and address, the capacity in which they were performing the role (that is parent or guardian, NIAAS, social worker) and the aspects of the custody process for which they were present. Appropriate adults were able to speak to detainees in the solicitors' consultation room in private, when they initially arrived and in advance of an interview.

Safeguarding of children

5.31 The PSNI's custody staff had a focus on diverting young people away from custody where possible. While the reasons for detention were always recorded, there were occasions where there could have been better recording about what alternatives (if any) had been considered by the arresting officer and why they were deemed not to be a suitable course of action. Where children were brought to custody it was clear that staff were focused on reducing the time they were held in custody if they were detained. This was particularly apparent in cases involving younger children as case example 4 demonstrates.

Case example 4

A 13-year-old boy who was a 'Looked After' child, resident in a children's home, assaulted a member of staff on the way back from an out-of-home activity. On his return to the children's home he caused criminal damage and the police were called late that night. He was arrested for the assault on the staff member, criminal damage and threats to kill and brought to the custody suite. A flag on NicheRMS stated that he had been brought to custody the previous month and the Forensic Medical Officer had deemed him not to be fit for detention or interview due to his mental health issues and previous self-harm and suicidal tendencies. The custody officer on duty had previous knowledge of the boy. In his notes on the custody record he referred to the flags highlighting the fact the boy had autism, ADHD and learning difficulties, as well as his mental health issues. The Custody Sergeant contacted the on-call Forensic Medical Officer for advice about detaining the boy. The Forensic Medical Officer agreed with the decision of the previous Forensic Medical Officer and the Custody Sergeant declined to authorise the boy's detention. He spent just over an hour in custody before being returned to the children's home.

5.32 Children were all reviewed by a health care professional on arrival, including if they were subject to the use of force. Custody staff were generally aware of the children and young people who were regularly brought to their custody suites, particularly those from a children's home. Some staff described the rapport they had built up with these children in an effort to reassure them.

- 5.33 The risk assessment process required the Custody Sergeant to pay particular cognisance to detainee’s disabilities, communication difficulties, health conditions and substance misuse. The appropriate adult scheme was key to assisting with these where the young person was not in the care of social services. The registered intermediary scheme was also available to assist those detainees who had learning and communication difficulties and Inspectors saw this scheme used in a case where the detainee was a child in the custody record analysis. Flags on NicheRMS highlighted those that had previous contact with the Public Protection Branch for suspected child abuse or had been involved in the Multi-Agency Risk Assessment Conference as a high-risk victim of domestic abuse.
- 5.34 For ‘Looked After’ children or those involved with social services there were inconsistencies in the availability of information to alert Custody Officers to these risks. In some cases there were flags on NicheRMS to highlight that the child was ‘Looked After’, on the Child Protection Register or that a named social worker was to be informed if the child was arrested. If children were arrested after a call from a children’s home (either because of an offence committed in the home or against staff or to report a child as missing) then officers should be aware of the child’s ‘Looked After’ status. Other than that, officers relied on knowledge of the child from previous encounters or the child’s self-report that they were ‘Looked After’.
- 5.35 A concern for Inspectors was the lack of consistency of this information and particularly, a lack of consistency about the information available that the child was on the Child Protection Register or subject to a care order. It was not clear to Inspectors how officers would be fully aware in every case as to whether social services was involved in the child’s life. This could be for a range of reasons including because there was suspected physical, sexual or emotional abuse from one or both of their parents or because of concerns around the young person’s behaviour with a partner or child. The exception was where there was an ongoing investigation by the PSNI’s Public Protection Branch and this was indicated on NicheRMS. This impacted on the Custody Sergeant’s ability to make fully informed decisions about the involvement of parents as appropriate adults or about the need to inform a social worker about the child’s arrest. An example of the complexity of this information is illustrated in case example 5.

Case example 5

A 15-year-old boy was arrested late at night for road traffic offences involving a suspected stolen vehicle. Reviewing the history of the boy's previous contact with police showed that he had been involved with social services and police since his early years. The reasons for this varied; initially as a victim of crime, as a witness to domestic abuse between his parents (who had since separated) and more recently as an offender. He had previously been arrested for a sexual offence. Social services was also currently involved with him because of concerns about his current relationship with a girl who had special educational needs and was reported to be pregnant with his child. It is acknowledged that this information, while held on NicheRMS, required a considerable amount of reading by the CJI Inspector and it is unlikely a Custody Sergeant in a busy suite would have had time to review all of it.

There was no note on the custody record to state whether the boy was, or had ever been, on the Child Protection Register or to indicate that social services should be informed of his arrest. His mother was informed of his arrest shortly after he arrived in custody and attended the following day to act as an appropriate adult. There was nothing to indicate whether his mother was suitable to act in this role. While it is likely that this case would have been reviewed by the Youth Diversion Officer in their daily review, it highlights how difficult it would be for custody officers to have the full facts required to undertake a risk assessment at the time. It is therefore unclear as to how they could be expected to discharge their responsibilities in respect of safeguarding and welfare appropriately.

- 5.36 There did not appear to Inspectors, at the time of the inspection, to be consistent and up-to-date information available to Custody Sergeants on NicheRMS to indicate whether children brought to custody were currently on the Child Protection Register. There is therefore a potential risk of the use of a parent as an appropriate adult, who would not be considered to be appropriate for the role because of the risks to the child or of a lack of information sharing about welfare concerns in the immediacy of the initial period of detention. One example Inspectors were told of by a member of custody staff highlights this issue.

Case example 6

A child was brought to custody from a children's home. The child wanted to contact their father but the Custody Sergeant had concerns about the suitability of him as an appropriate adult. The Custody Sergeant telephoned the on-call social worker who didn't have access to further information. The Custody Sergeant then rang the children's home who confirmed that the child was only to have supervised contact with the father but was able to speak to their mother.

- 5.37 The issue of information sharing and access to information from the Child Protection Register arose in CJI's recently published inspection of CSE⁶². The PSNI agreed a report recommendation that *"The PSNI introduce without delay the proposed IT process to alert within its system children on the Child Protection Register"*. In their Action Plan⁶³ in response to the report the PSNI indicated that this work had been completed with the objective *"To work closely with Health & Social Care Trusts to share information of children on the Child Protection Register (CPR). This information will be recorded on police information systems in order to inform officers who are engaging with children and families."* **Area for improvement: the Police Service of Northern Ireland should introduce without delay the proposed information technology process to alert within its system children on the Child Protection Register and ensure it applies to custody records.**

Overnight detention of children

- 5.38 Article 39(6) of PACE (Northern Ireland) set out the law in respect of holding children and young people in police custody as being a 'last resort':

If a juvenile is charged with an offence and the custody officer authorises their continuing detention the custody officer must:

(6) Where a custody officer authorises an arrested juvenile to be kept in police detention under paragraph (1), the custody officer shall, unless he certifies that it is impracticable to do so, make arrangements for the arrested juvenile to be taken to a place of safety and detained there; and it shall be lawful to detain him in pursuance of the arrangements.

(7) A certificate made under paragraph (6) in respect of an arrested juvenile shall be produced to the court before which he is first brought thereafter.

[F6(8) In paragraph (6) "place of safety" means any juvenile justice centre, any hospital or surgery, or any other suitable place, the occupier of which is willing temporarily to receive the arrested juvenile.]

In addition Article 37 of the UN Convention on the Rights of the Child⁶⁴ requires that 'States Parties shall ensure that:...(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time". The UK, including therefore the DoJ and other Northern Ireland Executive Departments, are required to report to the UN Committee on the Rights of the Child. The approach of the UK Government to children and young people in detention forms part of the Committee's examination of the state's compliance with the requirements of UNCRC.

62 CJI, *Child Sexual Exploitation in Northern Ireland: An inspection of the criminal justice system's response, June 2020*, available online at: www.cjini.org/TheInspections/Inspection-Reports/2020/April-June/Child-Sexual-Exploitation-in-Northern-Ireland.

63 Available on CJI's website at www.cjini.org/getattachment/7136a74d-9f04-41dd-886f-19160dc26f48/PSNI-Child-Sexual-Exploitation-Inspection-Action-Plan.aspx

64 United Nations, *Convention on the Rights of the Child, November 1989*, available online at: www.ohchr.org/en/professionalinterest/pages/crc.aspx

5.39 It was clear from discussions with staff and from the custody record analysis that custody staff recognised the need to avoid criminalisation of children and to have them removed from the custody environment as soon as possible. For example, in three cases in the case file reviews where the detainee was a child the Custody Sergeant did not authorise their detention. In other cases the detainee was not placed in a cell but was accompanied by their parent and processed as quickly as possible before being released from the suite. An example of this is outlined in case example 7.

Case example 7

A 17-year-old boy was involved in an organised fight with another boy. He had used a knuckle duster to cause injury to the other boy's face and was therefore arrested for Grievous Bodily Harm with intent. His mother arrived at the custody suite at the same time as he arrived and acted as an appropriate adult. The boy's risk assessment indicated he had autism and had previously attempted self-harm. Warning flags were added to NicheRMS. He was dealt with quickly and was kept in the care of his mother rather than being held in a cell during the period of detention. He was released on conditional bail after two and a half hours.

5.40 In most cases in the file reviews it appeared children were returned home with their parent/guardian who had acted as an appropriate adult. There were some issues about the recording of this with the custody record not always specifying that the parent or social worker had returned the child to their home therefore this had to be inferred from the record. Record keeping prior to release is covered further in Chapter 6, pre-release risk assessment.

5.41 There was a challenge for the PSNI in accessing safe accommodation for children under the care of HSCTs, particularly out of hours. The PSNI custody policy⁶⁵ clearly set out the responsibilities of both police and social services in securing appropriate accommodation for children and young people where necessary: *"If a parent or guardian refuses to provide accommodation, i.e. a suitable address for service of a summons, or the child's return home presents a risk to themselves or others, the child may need to be detained in their own interests.....If the return of a 'Looked After' child to their Children's Home placement is not possible for good reason e.g. to protect an injured party from further assaults, each Trust should have in place a range of alternatives to accommodate him/her, for example:*

- *an alternative residential placement;*
- *intensive support;*
- *emergency foster care; or*
- *a temporary return to family or extended family."*

65 PSNI, *Custody Policy*, May 2018, available online at: <https://www.psni.police.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/custody-service-policy-310518b-external---policenet-link-removed.pdf>

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- 5.42 Inspectors did not see any cases in the sample where the Custody Sergeant attempted to access a bed in a children's home for a child whose parents were unable, unwilling or unsuitable to take them home but were advised by custody staff that social services were unable to offer any alternative accommodation. In these cases children were held in a cell until the following morning when their parent attended custody and took them home. Work was being undertaken by the Youth Justice Agency and its partners as a result of the 2016 Youth Justice Scoping Study, with the aim of repurposing of Woodlands JJC with Lakewood Centre for Young People to create a secure campus. Inspectors were advised that this included an intention to provide improved community satellite provision, including accommodation, to reduce the need for children to be admitted to secure accommodation under PACE. The Youth Justice Agency continued to support young people through the Bail Information Scheme which was in place to ensure that bail information was presented to the court at the young person's first appearance.
- 5.43 The PSNI's guidance around escorting of juveniles to Woodlands JJC stated '*When it has been established that a juvenile in police custody requires to be detained overnight in the Juvenile Justice Centre, the custody officer should make contact with the Juvenile Justice Centre to ascertain that suitable accommodation is available.*' Custody staff reported that staff at Woodlands JJC were helpful in identifying a bed available before an allocated cut-off time. Children were therefore not transported to Woodlands JJC in the middle of the night and nor were they transported significant distances, meaning that most PACE detainees were transferred from Musgrave custody suite in Belfast. In the case file reviews there were only two children charged and refused bail; one child was transferred to Woodlands JJC under PACE (a second child was transferred to Woodlands JJC but for breach of bail), the other remained in a police cell.
- 5.44 The Youth Justice Agency Workload Statistics Bulletin⁶⁶ reports movements within the JJC including where young people have been admitted and left under PACE. The 2018-19 report stated: "*Over the past five years there has been a general increase in the proportion of movements attributed to PACE (36.1% in 2014-15; 49.9% in 2018-19). The proportions of movements attributed to remand and sentence movements have both decreased over the five year period (54.1% to 44.2% and 9.8% to 5.9% respectively).*" The Bulletin also includes consideration of the number of PACE admissions compared to the number of PACE outcomes to create a conversion estimate, that is, of all young people admitted into the JJC on PACE how many are subsequently remanded by court or sentenced to custody? The Bulletin states "*the PACE conversion rate decreased from 49.1% (132) in 2017-18 to 41.2% (94) in 2018-19, representing an increase in the percentage of young people admitted to the JJC on PACE having been released without having been*

66 DoJ Analytical Services Group. Northern Ireland Youth Justice Agency Annual Workload Statistics 2018/19: YJA Statistical Bulletin 2019, November 2019, available online at: www.justice-ni.gov.uk/sites/default/files/publications/justice/YJA%20Workload%20Statistics%20bulletin%202018-19.pdf

- remanded by court or sentenced to custody*". Although this is an estimation the figures indicate a worrying trend for the use of PACE for those young people charged but who will not subsequently be remanded by a court.
- 5.45 The Bulletin also reports an increase in the proportion of movements within the JJC involving young people subject to care orders or in voluntary accommodation from 2014-15 (38.8%) to 44.9% in 2018-19, peaking at 54.0% in 2017-18. This highlights the issues raised elsewhere in this report about the increased criminalisation of young people in the care system.
- 5.46 In the detainee survey 100% of those aged 21 or under (12 of 12) confirmed they felt safe in the custody suite, compared to 83% (25 of 30) for those aged 22 or over. While there were no longer cells allocated as 'juvenile cells' in the suites custody staff in some suites suggested they would keep children and young people in cells close to the custody office or separate from the rest of the detainees.
- 5.47 There were female CDOs in many of the teams working in custody to meet the welfare needs of girls under the age of 18. Where a female CDO wasn't available a female officer from a Local Policing Team was usually identified and attended before the detainee arrived and then was involved in the searching procedure and any welfare needs.
- 5.48 Chapter 1 of the PSNI Conflict Management Manual⁶⁷ states: *"Special consideration should be given to the heightened vulnerabilities of children and members of other vulnerable groups in relation to the use of force. Although not incorporated into domestic legislation, officers should take cognisance of the United Nations Convention on the Rights of the Child (UNCRC). Article 3 of the Convention requires the best interests of children to be a primary consideration in all actions concerning children."* It should be noted that although this is not incorporated into domestic legislation it is binding international law ratified by the UK Government.
- 5.49 In the custody record analysis there were only four custody records which showed that the detainee had been strip-searched and none of these detainees were children. Data provided by the PSNI showed that of 1,045 strip-searches conducted in 2018-19, 58 (6%) were conducted on children and young people.

67 PSNI, *PSNI Manual of Policy, Procedure and Guidance on Conflict Management: Chapter 1: Legal basis and human rights*, April 2013, available online at: https://www.psni.police.uk/globalassets/advice--information/our-publications/conflict-management-manual/chapter_1_-_legal_basis_and_human_rights.pdf.

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

EXPECTATION - GOVERNANCE OF HEALTH CARE

Planning

- 5.50 Strategic planning is a key part of delivering an effective service which meets the needs of people in police custody. Inspectors found some evidence of strategic planning between the PSNI, Belfast Health and Social Care Trust (BHSCT) and the Public Health Agency (PHA). A Task and Finish Group met monthly focussed on implementation of a new 'nurse-led' model of providing health care into custody suites. A monthly PSNI strategy meeting chaired by the Chief Superintendent also took place, which a BHSCT representative had begun to attend. The Chief Superintendent advised he was hopeful the model currently operating in Musgrave custody suite would in future be implemented throughout Northern Ireland to strengthen accountability and clinical governance of health care professionals working within custody suites. Inspectors heard that this model would address significant weakness in clinical governance highlighted in previous inspections. Inspectors were encouraged by feedback from clinical nurses working in the custody suite, custody staff and PSNI senior staff, that this new model had clear potential to improve oversight and accountability arrangements for health care staff working within all custody suites.
- 5.51 In relation to forward strategic planning at a policy level, PSNI senior officers demonstrated significant commitment to interdepartmental working between the DoH and the DoJ and advocated for strong collaboration on future initiatives to improve the outcomes for detainees. Inspectors heard of discussions on a potential shared funding model between the DoH and the PSNI and hopes this would support the continued implementation of partnership working.

Oversight and monitoring

- 5.52 The interagency Task and Finish group did not have a role in providing oversight or accountability for the work carried out by Forensic Medical Officers (FMOs) outside of Musgrave custody suite. Future mechanisms for shared accountability and monitoring of the quality of care, between the PSNI and HSCTs for a future health care delivery model had not yet been developed.
- 5.53 Senior PSNI staff across the region involved in planning and monitoring the service provided by FMOs described contractual arrangements to assure the PSNI of the fitness to practice, revalidation and completion of a range of pre-employment checks. Inspectors were advised when issues arose in relation to clinical practice, response times to attend suites, or other general concerns or complaints, these were resolved through communication with locality based Administrative FMOs who would liaise with the relevant FMO.

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- 5.54 All FMOs working across the region were either practicing or retired General Practitioners (GPs). For GPs, practice appraisal arrangements were facilitated through the Integrated Care Directorate with the HSCB. The RQIA heard that where incidents or concerns arose in relation to the practice of an FMO, PSNI staff had informed the Responsible Officer (RO) within the HSCB. The DoH guidance indicates the RO in the HSCB would be required to consider the whole practice of the GP during the process of revalidation. This would include work provided services under contract with the PSNI. Formalised arrangements for sharing information between the PSNI and ROs in the HSCB about the practice of GPs working as FMOs were not yet in place.

Learning from incidents and complaints

- 5.55 At an operational level, weekly operational custody meetings facilitated discussions about safety which included health issues or learning arising from concerns, complaints and incidents.
- 5.56 Two IT systems operated to collect information in relation to health related incidents or concerns. Across the region the PSNI used the E23/10 within all custody suites. Within Musgrave custody suite health care professionals employed by the BHSC used a system called Datix. Inspectors found that there were no formal systems to communicate and share learning arising from incidents recorded on E23/10 or Datix to FMOs across the region. Within Musgrave custody suite the closer joint working arrangements and weekly meetings facilitated some opportunity for sharing of such information and Inspectors heard that information was regularly disseminated to both health care professionals and custody staff. The sharing of learning between the PSNI and health care staff, including FMOs, was working more effectively in Musgrave custody suite than in the rest of the region. There was no evidence of established systematic arrangements to seek, analyse interrogate and investigate complaints, trends or serious incidents jointly between HSCB staff and the PSNI.
- 5.57 Despite the strong desire to progress the implementation of the new health care model outside of Musgrave custody suite, it was clear that the current mixed model for the provision of health care would continue to operate for some time, due to the uncertainties around funding and the time to roll out the model once it is agreed. Mechanisms should therefore be developed to address effectively, with FMOs, issues such as timely response to calls or referrals, consistency in practice relating to the storage of clinical records and arrangements for access to the Northern Ireland Electronic Care Record (NIECR). The PSNI should also formalise arrangements through the HSCB RO for raising concerns in respect of the individual practice of GPs/FMOs providing services to the PSNI under contract.

STRATEGIC RECOMMENDATION 3

The Police Service of Northern Ireland and Health and Social Care Trusts should collaborate effectively to expedite the implementation of the nurse-led custody model across Northern Ireland and with interdepartmental strategic support.

STRATEGIC RECOMMENDATION 4

Inspectors recommend that **systems should be developed and implemented at both operational and senior managerial level within the Police Service of Northern Ireland and the Belfast Health and Social Care Trust for the joint analysis of incidents/complaints by health care professionals/Forensic Medical Officers to ensure that learning is identified and shared both between the Police Service of Northern Ireland and health care staff and between health care staff and Forensic Medical Officers across all custody suites.**

STRATEGIC RECOMMENDATION 5

Inspectors recommend that **the Police Service of Northern Ireland should develop and implement systems through locality/district based Administrative Forensic Medical Officers, Responsible Officers at the Health and Social Care Board and through the General Medical Council where required for resolving professional practice concerns or complaints. These systems should focus on continuous improvement in quality and ensuring consistency in respect of the services provided.**

EXPECTATION - PATIENT CARE

- 5.58 Generally access to FMOs for the medical assessment of detainees was good. In some rural stations custody staff reported instances of delayed response, at times up to four hours, before FMOs were available to attend the custody suite. Delayed response times impacted on the provision of medical assessments and prescribing of medications for detainees. Availability of a 24 hour nursing service in Musgrave custody suite was in place to meet most detainee care needs.
- 5.59 The provision of health care related training for custody staff included annual training on resuscitation equipment, with first aid training completed every three years. Training on the safe use of needles/handling of sharps was provided to custody staff during induction; however custody staff advised that they had not received training on dealing with blood or body fluids. Mental health training was less formalised with some staff members reporting learning through experience and others sourcing training online. An extensive range of appropriate training

was available for nurses working in Musgrave custody suite, provided mainly by the BHSCT. **Area for improvement: the Police Service of Northern Ireland should review the provision of health care training to ensure that custody staff are equipped with the appropriate skills to effectively meet the needs of detainees.**

- 5.60 Most medical rooms inspected were uncluttered and provided appropriate privacy for health care consultations. Within Musgrave custody suite, health care facilities were well equipped and maintained to a high standard. In other custody suites some of the medical rooms were not cleaned to the required standard and some were awaiting refurbishment to meet the required specification. There were plans to complete refurbishment of all medical rooms which was underway and scheduled to be completed by May 2020⁶⁸.
- 5.61 Some domestic stores within the custody suites were disorganised and not cleaned to expected standards. Inspectors found mops for use in cells and food preparation areas stored together, increasing potential for cross-contamination and spread of infection, as well as mops soaking in dirty water. Not all staff were sufficiently knowledgeable in relation to cleaning products or methods and necessary arrangements for decontaminating reusable items such as cloths. Inspectors were not assured that all domestic stores and cleaning items were being cleaned effectively and advised that arrangements should be established to ensure this is completed on a regular basis.
- 5.62 The RQIA Inspectors examined the cleaning schedules and could not find evidence of a systematic approach to assessing the standard of cleanliness or verifying that cleaning had been completed. This was evident in all suites and in particular Banbridge Station. Inspectors found variation in the frequency of supervisor's audit checks in the custody suites, and were concerned about the effectiveness of oversight of cleaning service provision. The RQIA believe that the PSNI should define the expected standards in respect of cleaning of clinical and non-clinical areas within custody suites and ensure cleaning contracts include robust monitoring and oversight of compliance with these standards.
- 5.63 Cleaning staff lacked formalised training, either through the PSNI or the organisation which held the contract for cleaning services across all PSNI stations. Some cleaning staff reported that, other than their induction, they had not received any training during the previous three-year period. The PSNI must ensure that staff receive adequate training to support the ongoing provision of a safe and effective cleaning service.

68 The refurbishment programme was affected by the Covid-19 pandemic and therefore was not completed by May 2020 and was continuing at the time of publication.

- 5.64 An out-of-hours cleaning service was available. Custody staff highlighted that on occasion, over bank and public holidays, there were difficulties in accessing out of hours cleaning services, leading to delays in cells being made available for use. The PSNI should review the cleaning contract to ensure that it continues to deliver a service appropriate to the needs of the organisation.

OPERATIONAL RECOMMENDATION 3

Inspectors recommend that **the Police Service of Northern Ireland should define the required standards in respect of the cleaning of clinical and non-clinical areas within custody suites. The Police Service of Northern Ireland must ensure robust monitoring and oversight of compliance with these standards.**

Medical equipment

- 5.65 In most custody suites RQIA Inspectors found systems for checking resuscitation equipment, including the AED and oxygen cylinders. In most cases these checks were completed by custody staff on a monthly basis, however, oxygen masks and tubing were found to be out of date in one custody suite, indicating that the checking systems were not effective and there was a risk of out of date equipment being used in the treatment of detainees.
- 5.66 Audit and oversight in relation to first aid boxes was poor. Some of the contents of first aid boxes were found to be out of date. This included saline, sterile water, oral glucose, pocket masks and dressings, which were found to be consistently out of date across all custody suites. First aid boxes, and their contents, were often found to be dusty and untidy. In one custody suite the contents of the first aid box was contaminated with blood. Not all first aid boxes included an expected list of contents. In most custody suites staff were unaware of who was responsible for completion of these checks, how often these should be carried out and who was responsible for ordering replacement stock. The RQIA would advise that procedures should be implemented to ensure first aid boxes are checked regularly and are adequately stocked and cleaned to reduce the risk of cross-infection or of unsafe equipment being used.
- 5.67 Large bags of resuscitation equipment, purchased for the G8 Summit in 2013, remained in place in most custody suites. The majority of the equipment within these bags was out of date during the previous inspection in 2016, and the same equipment remained in place. The RQIA again advise these items should be disposed of to avoid the risk of unsafe equipment being used in the treatment of detainees.

- 5.68 Sharps boxes must be dated on assembly and labelled to indicate the site of origin and staff member who assembled the box. This had not been completed in many of the treatment rooms visited. Inspectors advised that the PSNI must ensure this is completed in all cases. This ensures full traceability in the event of spillage of sharps waste from the box or an injury to a staff member as a result of incorrect assembly or disposal. Identifying the origin of the sharps box may assist in the immediate risk assessment process carried out following injury and also identify all staff at risk and the correct procedures to employ.
- 5.69 Inspectors noted that personal protective equipment (PPE) was widely available across all custody suites. It was observed that PPE was being used appropriately by custody staff to reduce the risk of cross-infection⁶⁹.

OPERATIONAL RECOMMENDATION 4

The Police Service of Northern Ireland should identify all health care equipment required to be held in custody suites. It must ensure systems and processes are implemented, with clearly identified roles and responsibilities, and regular audits, to ensure health care equipment is available and safe for use.

- 5.70 Within Musgrave custody suite, nurses could view the detainee's medical records through the NIECR. This ensured continuity of health care and appropriate prescribing whilst in detention. PACE 15, which contained details of the detainee's medical examination, and PACE 15/1 forms, which detailed any prescribed medicines (completed by registered nurses), were appropriately completed, filed and archived at timely intervals. Detainees continued to receive their prescribed medicines obtained at the time of arrest or supplied by family while in custody.
- 5.71 NIECR access was available in Dungannon and Omagh suites. Senior PSNI staff supported expanding access to the NIECR within other suites, to increase the availability of information about detainees to FMOs. The RQIA advised that the PSNI should engage with FMOs and the e-health team in the HSCB to identify and clarify the required procedures for FMOs to access the NIECR in all custody suites.
- 5.72 Variable practice was noted with regards to completion and storage and filing of PACE 15, PACE 15/1 and additional clinical records outside Belfast. Some FMOs recorded all of the clinical details on the PACE 15 forms which were retained in the custody suite, whilst others made additional notes retained individually which the PSNI could not access and which did not enable the PSNI to seek assurances of the standard of care delivered. Clear protocols outlining expectations for the completion, storage, retention and disposal of clinical records should be developed

69 This information pre-dates the Covid-19 pandemic, which has significantly increased the need for PPE in custody suites, and the concerns raised across the health and justice sectors about the inability to source sufficient PPE.

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and implemented. Consideration should be given to the implementation of an internal electronic recording system to replace the paper-based PACE 15 and 15/1 forms which can be used by FMOs to record and share medical information on detainees.

- 5.73 The management and storage of medicines within Musgrave custody suite was safe and effective. Comprehensive policies and procedures for the management of medicines which included Patient Group Direction (PGDs)⁷⁰, home remedies and emergency medicines were in place. Medicines belonging to the BHSC and administered by registered nurses were stored in the medical room and levels of stock were appropriate. Only registered nurses had access to these medicines. FMOs had their own individual supplies of medicines and only used medicines from their own supply.
- 5.74 Medicines within other custody suites were stored in a locked cupboard within the medical room. The Administrative FMO was responsible for the ordering, receipt and disposal of medicines. Inspectors were unable to find records of these transactions within the suites. All FMOs for each suite (except Musgrave custody suite and Antrim) shared the one supply of medicines, including Schedule 3 and 4 controlled drugs. As such prescribing practices could not be effectively audited. This practice was not in line with expected professional and legal requirements. Inspectors were assured that work was progressing to ensure that each FMO retained an individual supply of medicines⁷¹.
- 5.75 In two of the custody suites the keys for the medicines cabinet were accessible and not securely locked in the key boxes. In one custody suite, medicines were left by the FMO for the CDO to administer should the FMO give authorisation by telephone. Inspectors advised the Custody Sergeant in these suites that this practice was not appropriate and access to medicines should be restricted to only those authorised to prescribe/administer.
- 5.76 Out of date medicines, including emergency medicines and insulin, were found within medicine cabinets and refrigerators in some suites. A system should be implemented to ensure that out of date medicines are routinely identified and disposed of.
- 5.77 A medicine's refrigerator containing insulin and other medicines which required cold storage was located in all medical rooms. Inspectors found that the temperature of this refrigerator was not monitored in any of the custody suites except Musgrave custody suite. Medicines which require cold storage must be stored between 20°C and 80°C to ensure that they remain viable. Inspectors advised that arrangements must be made to ensure that refrigerators are maintained within the required temperature range to ensure medicines are safe for use and effective.

70 See www.gov.uk/government/publications/patient-group-directions-pgds/patient-group-directions-who-can-use-them

71 Inspectors were advised in February 2020, after completion of the fieldwork, that this work was completed.

OPERATIONAL RECOMMENDATION 5

The Police Service of Northern Ireland should engage with Forensic Medical Officers and the e-health team in the Health and Social Care Board to consider arrangements for Forensic Medical Officers and health care staff to access the Northern Ireland Electronic Care Record in all custody suites. Policies and procedures should be developed and implemented to ensure clinical records are completed, stored and retained in line with professional standards and legal requirements. These should be subject to audit and compliance assured.

OPERATIONAL RECOMMENDATION 6

Policies and procedures for the management of medicines should be developed and implemented to standardise processes across all custody suites and to ensure that the use of medicines in custody is in line with professional and legal requirements. This should include:

- **ensuring Forensic Medical Officers access only their own individual supply of medication; and**
- **ensuring medicines are in date and stored securely at the appropriate temperature.**

EXPECTATION - SUBSTANCE MISUSE

5.78 The service provision for management of drug and alcohol misuse in custody suites was minimal. Custody staff reported experiencing an increase in the number of detainees with addiction issues. Of detainees surveyed 33% (14 of 42) confirmed they had drug and alcohol problems. Custody staff told Inspectors it was sometimes difficult to differentiate between mental health problems, alcohol intoxication or drug induced psychosis.

5.79 PSNI officers could take detainees to collect medication from a community pharmacy when they had been prescribed and commenced on Opioid Substitution Therapy in the community. A leaflet signposting detainees to drug and alcohol services was available which the custody staff and FMO could issue.

EXPECTATION - MENTAL HEALTH

- 5.80 Custody mental health provision was delivered by the PSNI's custody staff and FMOs across all suites. This service was augmented within Musgrave custody suite with the addition of mental health nurses as part of the new model of health care. All custody staff and FMOs reported they experienced an increase in detainees with mental health problems, drug and alcohol addiction entering custody.
- 5.81 Timely access to mental health professionals varied, dependent on custody staff recognising and responding to a detainee's mental health needs. Custody staff's awareness of detainees' mental health requirements is thus crucial in making timely referrals to the FMO.
- 5.82 Custody Sergeants could describe signs of mental ill health and how they would manage deteriorating symptoms. This knowledge was largely gained through experience in supporting people with mental health conditions and by learning from colleagues. CDOs desired further mental health awareness training to help them meet the changing needs of the detainee population. Senior PSNI staff confirmed that plans had progressed to deliver such training for CDOs as part of their regular learning event.
- 5.83 Local arrangements existed between custody suites and health care providers to provide mental health advice and support but Inspectors found it varied between localities and HSCTs. Some custody staff reported access to mental health professionals could be problematic with a delayed response at times. In other cases staff reported timely access to professionals with mental health teams attending custody suites quickly. Of the detainees surveyed 40% (17 of 42) reported having mental health issues in 2019 with only 13% (2 of 16) confirming they were seen by a mental health nurse or psychiatrist.
- 5.84 In Musgrave custody suite, the new health care model ensured prompt seven day access to mental health professionals. A service level agreement was in place with the BHSCT and referrals were made following assessment by custody staff. Inspectors found evidence of therapeutic interventions being delivered by mental health nurses. Detainees were also provided with an information leaflet on release to signpost them to support services such as Samaritans and Lifeline (see Chapter 6). Inspectors noted inequity in provision between Musgrave custody suite and the other custody suites in the region.

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- 5.85 Article 130 of The Mental Health (Northern Ireland) Order (1986)⁷² states police custody is not a place of safety for someone requiring detention under the Mental Health Order (MHO) and should only be used as a last resort but never for children as noted previously. Figures provided by the PSNI showed that in 2018-19, 47 detainees were detained under Article 130 of the Mental Health (Northern Ireland) Order (1986); 45 times for an adult and twice for a detainee who was a child.
- 5.86 Through discussion with custody staff variation was noted in the extent to which custody suites were used for the detention of detainees requiring acute mental health hospital admission under Article 130. In Antrim custody suite Inspectors found clear guidance for staff advising police custody is not a place of safety under the MHO but in other custody suites, there were several instances of detainees remaining in the custody suite for several days whilst waiting for a hospital psychiatric bed.
- 5.87 Inspectors advised that the PSNI should ensure effective arrangements to monitor the use of Article 130 and ensure it is being used effectively.

STRATEGIC RECOMMENDATION 6

The Police Service of Northern Ireland and health care providers should define the current arrangements for the access to acute mental health care for detainees in custody suites and agree on a suitable model to ensure equity of access across Northern Ireland. These arrangements should reinforce the appropriate use of Article 130 of the Mental Health (Northern Ireland) Order 1986 which should be clearly communicated to health care professionals working in these environments.

72 See www.legislation.gov.uk/nisi/1986/595/article/130.

LIST OF ABBREVIATIONS

CHIEF INSPECTOR'S FOREWORD

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RECOMMENDATIONS

CHAPTER 1: INTRODUCTION

CHAPTER 2: LEADERSHIP, ACCOUNTABILITY AND PARTNERSHIPS

CHAPTER 3: PRE-CUSTODY: FIRST POINT OF CONTACT

CHAPTER 4: IN THE CUSTODY SUITE: BOOKING IN, INDIVIDUAL NEEDS AND LEGAL RIGHTS

CHAPTER 5: IN THE CUSTODY CELL, SAFEGUARDING AND HEALTH CARE

CHAPTER 6: RELEASE AND TRANSFER FROM CUSTODY

APPENDICES

CHAPTER 6: **RELEASE AND TRANSFER FROM CUSTODY**

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

EXPECTATION - PRE-RELEASE RISK ASSESSMENT

- 6.1 NicheRMS guided Custody Sergeants through the pre-release risk assessment process, in the same way as the booking in and initial risk assessment processes, with a series of prompts and questions to be completed. This required consideration of the same potential risks as at the beginning of the period of detention (suicide, self-harm, mental or physical health issues etc.). The first question of the pre-release risk assessment was a drop down option to select if the detainee was vulnerable by virtue of, among other things, age, that is, that they were a child under the age of 18. In the records reviewed several responses to this question were marked 'no' for child detainees.
- 6.2 In many cases in the custody record analysis the detail of these risks was limited, with either copied information from the initial risk assessment or a brief standard phrase that the detainee had been provided with a referral sheet. In some cases details of the risks were missed or there was insufficient description of what had been done to address them during the period in custody. In half of the cases (20 of 40; 50%) in the thematic case audits Inspectors assessed that all identified risks were not sufficiently considered and addressed in the pre-release risk assessment. Flagged information was added to NicheRMS at the point of release, relating to the detainee's risk assessment or issues during their time in custody.

OPERATIONAL RECOMMENDATION 7

Inspectors recommend that **the Police Service of Northern Ireland should develop an action plan to improve the quality of analysis and recording of pre-release risk assessments within three months of the publication of this report.**

- 6.3 The PSNI provided every detainee leaving custody with a referral leaflet entitled 'Advice to Persons Released from Police Custody', which included contact information for support organisations across a variety of issues including medical treatment, suicide and self-harm, domestic abuse, substance abuse etc. as well as details of the OPONI. Custody staff in Musgrave custody suite advised that the custody nurses had greatly assisted in signposting and offering support for detainees leaving custody and could make arrangements with community services for appointments or follow-up contact. Where the detainee had been arrested and detained on suspicion of a sexual offence, the interviewing officers from the PSNI's Public Protection Branch provided them with additional support information, tailored for their circumstances. This was also positive although the provision of this was not routinely recorded in the custody record.
- 6.4 Mindwise ran a project called 'Linked-In' in Belfast, Antrim and Derry/Londonderry, which worked with young people, aged 13-24, who were due to leave or had just left police custody. The aim of the project was to reduce re-offending and improve mental health and well-being by helping young people to address factors that impact negatively on their lives. This provided individually tailored support, advocacy, a befriending service and signposting for a period up to six months to young people and young adults who had been in contact with the police. This was a positive approach to trying to break the cycle of offending for young people.
- 6.5 In some cases involving children and vulnerable detainees, such as those requiring the services of an appropriate adult, the custody record did not specify into whose care the detainee was placed or how the PSNI had ensured that they had got home safely. Staff highlighted concerns with releasing vulnerable detainees who had quantities of medication or legal highs in their property which they were handed back on release. In one case CJI asked the PSNI to check the whereabouts and welfare of a 15-year-old girl from Eastern Europe whose custody record contained no evidence of who her parents were, that they had attended custody, nor that she had been released into their care. On investigation by the Custody Sergeant and Investigating Officer it transpired that she had been picked up by her father but the lack of record of this demonstrated the need for the Custody Sergeant to satisfy themselves of the child's safety on release.
- 6.6 In some other cases where the detainee did not have the means to get home by themselves there was evidence that they were transported home by District officers, although this was ad hoc and dependent on available resources. This does not appear to be a cost effective solution or be the best use of already stretched police resources. **Area for improvement: the Police Service of Northern Ireland should consider options for the use of a travel scheme for detainees without access to funds or transport from family or friends.**

EXPECTATION - COURTS

- 6.7 Detainees were escorted to court from most custody suites by local police, tasked by operational planning. In Belfast an agreement had been reached whereby the Northern Ireland Prison Service Prisoner Escorting and Court Custody Service collected one prison van of six detainees from Musgrave custody suite and transported them to Laganside Courts. This still meant a significant number of detainees would require escorting by the PSNI if the suite was busy. The escorting arrangements to court will be considered further in CJI's forthcoming inspection of court custody.
- 6.8 Detainees arrived promptly for court in a timely manner where interviews had been completed and charging decisions had been made. Custody staff reported good working relationships with court clerks who they kept updated about the status of detainees who may be brought to court and who the court would accept before the cut-off time. There were inconsistencies in the processes for Saturday courts, with custody staff at some suites reporting a cut off time on Saturday mornings which would make it impossible for detainees to be fit for interview, interviewed, processed and taken to the requisite court in time. Staff expressed a frustration of then having to keep detainees over an entire weekend despite having complied with a process as best they could. Two examples from the custody record analysis highlight the lengthy periods detainees can spend in custody due to an inability to get to court in a timely manner.

Case example 8

A 23-year-old male was arrested at half past 10 on a Friday night for a violent offence and brought to custody. The risk assessment indicated that he was intoxicated under the influence of alcohol and drugs and had a previous history of attempted suicide or self-harm. The man had mental health issues and difficulties in reading and writing. The Custody Sergeant authorised detention shortly before midnight. The care plan recorded the need for Level 2 observations with 15 minute intermittent checks because of his intoxication. The man was reviewed by the health care professional during the night and there were good notes on the custody record of the subsequent changes to the care plan. The man's solicitor was contacted in the early hours of Saturday morning and attended the custody suite just before noon for interview. A decision to charge was made just before 4pm on Saturday and bail was refused. He was released from custody just after 10am on Monday morning to be transported to court. He was offered a shower prior to his release. The man had spent nearly 59 hours in total in custody.

Case example 9

When Inspectors visited Antrim custody suite a man was detained who had been arrested for theft from a large retail shop in Ballymena. He had been detained on Tuesday at 17:05 hours and was not due to attend court in Ballymena until Thursday morning. Inspectors were advised that custody staff had endeavoured to have him brought to court in Limavady on Wednesday but that it was impossible to meet the court cut-off time of 14:00 due to the time required for interview, the process of release and travel time.

- 6.9 Where detainees were transported from one custody suite to another this was dealt with by a local police crew but this did not happen frequently. Detainees who attended court were presented in their own clothes or the clothes provided in the custody suite. There was no use of video link for court hearings in custody suites. Discussions were ongoing between the judiciary and the PSNI about the location of Saturday courts and the potential for video link to be utilised but these had not progressed significantly⁷³. Inspectors would encourage the PSNI to continue working with partners to address these outstanding issues and explore the further use of technology to assist in this process. CJI will be undertaking a thematic inspection of transforming justice in the criminal justice system which will provide a further opportunity to review these issues.

73 The PSNI advised after the fieldwork for this inspection had concluded that video links to courts had commenced as a result of the Covid-19 crisis. This positive development in the pandemic should be built upon with legislative provision for use of video-link developed.

APPENDIX 1: EXPECTATIONS



EXPECTATIONS FOR POLICE CUSTODY

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

Version 3, 2016 (adapted for Northern Ireland April 2019)

Section 1: Leadership, accountability and partnerships

- Leadership.
- Accountability.
- Partnerships.

Section 2: Pre-custody: first point of contact

- Assessment at first point of contact.

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

- Respect.
- Meeting individual and diverse needs.
- Risk assessments.
- Individual legal rights.
- PACE reviews.
- Access to swift justice.
- Complaints.

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

- Physical environment.
- Safety - use of force.
- Detainee care.
- Safeguarding.
- Governance of health care.
- Patient care.
- Substance misuse.
- Mental health.

Section 5: Release and transfer from custody

- Pre-release risk assessment.
- Courts.

INTRODUCTION

This is the third version of *Expectations for police custody*, the standards by which outcomes for detainees in England and Wales and Northern Ireland in police custody are inspected. These *Expectations* are based upon those developed by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Prisons (HMIP) in 2016. They were updated in April 2018 to reflect differences between Northern Ireland and England and Wales in terms of the legislative, structural and operational landscapes.

The requirement to pursue a national programme of police custody inspections arises from the United Kingdom (UK) Government's ratification of the Optional Protocol to the United Nations Convention against Torture (OPCAT).⁷⁴ The Protocol acknowledges that detained persons are particularly vulnerable to ill-treatment, and that efforts to stop ill treatment should focus on prevention through a national system of regular independent visits to places of detention. Criminal Justice Inspection Northern Ireland (CJI) and the Regulation Quality Improvement Authority (RQIA) are two of the UK's 21 bodies committed to the regular examination of places of detention as members of the National Preventive Mechanism (NPM). In the UK the coordination of the NPM is the responsibility of HMIP.

The NPM must:

- regularly examine the treatment of people deprived of their liberty in places of detention;
- make recommendations to the relevant authorities with the aim of improving the treatment and conditions of detainees; and
- submit proposals and observations concerning existing draft legislation.

Inspections on the efficiency, effectiveness and treatment of detained persons in respect of police custody of the Police Service of Northern Ireland are conducted by CJI and the RQIA. *Expectations for Police Custody* sets out the framework and criteria used by the Inspectorates to assess police custody arrangements and the outcomes for those detained.

The *Expectations* are adapted from those developed by HMICFRS and HMIP for use by CJI and the RQIA in Northern Ireland. They are independent but are informed by the Police and Criminal Evidence (Northern Ireland) Order (PACE) 1989 and its Codes, professional guidance to the police on detention and custody⁷⁵, and international human rights standards relevant to police custody⁷⁶. They are also drawn from inspection experience and wider consultation with stakeholders, including police forces and non-police groups.

74 Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, A/RES/57/199, adopted 18 December 2003; came into force 26 June 2006.

75 College of Policing, *Authorised Professional Practice on Detention and Custody*, July 2015.

76 Association for the Prevention of Torture, *Monitoring Police Custody – a practical guide*, 2013.

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They incorporate learning from HMICFRS’s thematic inspection of the welfare of vulnerable people in police custody⁷⁷ and from the cumulative experience of our joint inspections of police custody to date. The *Expectations* for England and Wales were updated in May 2018, solely to reflect the requirements of the Policing and Crime Act 2017 in relation to bail and the introduction of released persons under investigation (see ‘Access to swift justice’). As this legislation is not applicable to Northern Ireland, the *Expectations* in this area still reflect existing provisions in relation to bail.

This updated version of the *Expectations* makes changes to promote the welfare and safety of people who will be the most vulnerable⁷⁸ in police custody. These include:

- an extension of the scope of inspection to include first contact and opportunities for diversion of vulnerable people;
- criteria for inspecting the PSNI on Section 75⁷⁹ equality duties as these affect custody;
- focused inspection criteria on the use of force;
- criteria reflecting strategic and operational outcomes on safeguarding the welfare of children (that is, all those under the age of 18) and vulnerable adults in police custody; and
- reporting on police cells used as a place of safety for people suffering acute mental ill-health.

The *Expectations* are used by CJI and RQIA Inspectors to assess the custody arrangements of the PSNI, with a particular focus on the treatment and conditions of those detained. They also offer a guide to the public, the PSNI and its partners involved in delivering services in police custody and the Northern Ireland Policing Board (NIPB) as to the standards we expect the service to meet.

Expectations are grouped under five inspection areas. They are:

- Leadership, accountability and partnerships;
- Pre-custody: first point of contact;
- In the custody suite: booking in, individual needs and legal rights;
- In the custody cell, safeguarding and health care; and
- Release and transfer from custody.

Expectations set out the outcome we expect the PSNI to achieve.

77 Vulnerability is linked, in many cases, to a minority status that increases the risks of stigmatisation and ill-treatment. Individuals therefore may be vulnerable in a given context and not in another. HMIC, March 2015, *The welfare of vulnerable people in police custody, March 2015*.

78 The inspectorates adopt the interpretation of ‘vulnerability’ proposed by the International Association for the Prevention of Torture (APT) (*Monitoring Police Custody – a practical guide*, APT 2013).

79 Section 75 of the Northern Ireland Act (1998) places a duty on public authorities to have due regard for the need to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- men and women generally;
- persons with a disability and persons without; and
- persons with dependants and persons without.

Indicators suggest evidence that may demonstrate whether the outcomes have been met. The PSNI does not have to meet each indicator; the list is not exhaustive and does not exclude other means of achieving the outcome.

This updated version of the *Expectations* takes effect from April 2019.

SECTION 1: LEADERSHIP, ACCOUNTABILITY AND PARTNERSHIPS

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

Expectations - Leadership

1.1 There is leadership by the Chief Officer Group which communicates a clear focus on protecting and diverting vulnerable people from custody, wherever possible, and promotes the safe and respectful delivery of custody.

Indicators

- There are PSNI-wide objectives concerning the diversion of vulnerable adults and children away from custody. These are promoted and accessible to staff.
- There is an effective management structure that ensures appropriate policies and procedures for the whole custody process are in place, fully implemented and reviewed regularly. Policies and procedures are accessible and staff understand them.
- There are sufficient resources to carry out the custody functions to ensure the safety and well-being of detainees.
- Services provided externally to support custody are monitored and scrutinised to hold providers to account.
- Custody suites are staffed with personnel (including contracted staff and volunteers) who are trained, have the right skills and understand how to respond to detainees. Their training needs are assessed, met and evaluated to perform the requirements of the role.

References*

ICCPR 10 (1)
CRC 3, 37, 40
CCLEO 2, 6
BOP 1, 4, 5, 9, 29
PPMI 1, 2, 20

*Please see list of acronyms at the end of this document for further information.

1.2 There is an evident and effective focus on the protection of children and vulnerable adults. In particular:

- the welfare of children is promoted and, where possible, criminalisation is avoided; and
- the welfare of vulnerable adults is promoted and police custody is only used as a place of safety for Article 130 of The Mental Health (Northern Ireland) Order⁸⁰ assessments in the most exceptional circumstances.

Indicators

- Safeguarding of children is embedded at a strategic level, supported by clear policies and procedures specific to the needs of children. Police Officers and staff are trained to recognise child sexual exploitation and to understand the need to safeguard and promote the welfare of children, and are supported to do so (see section 4).
- The strategic approach recognises the importance of avoiding the criminalisation of children and sets clear objectives in relation to this.
- Staff are provided with training and awareness of human trafficking, extortion and smuggling. All staff are alert to the signs that a detainee has potentially been a victim of trafficking and know how report it, and do so appropriately.
- The PSNI is represented on liaison groups or a local multi-agency Article 130 group, which monitors the use of Article 130, identifies any problems with interagency working and develops effective solutions to ensure police custody is not used for Article 130 Mental Health (Northern Ireland) Order assessments or other people in need of specialist mental health care, unless in exceptional circumstances.
- The PSNI has a robust adult safeguarding policy (see section 4) which is informed by the Northern Ireland Adult Safeguarding Policy '*Adult Safeguarding: Prevention and Protection in Partnership*' that all adult safeguarding activity must be guided by five underlying principles:
 - a right-based approach;
 - an empowering approach;
 - a person centred approach;
 - a consent-driven approach; and
 - a collaborative approach.

References

ICCPR 10 (1)
ICESCR 12 (1)
CRC 3, 37, 40
CCLEO 2, 6
PPMI 1, 2, 20

80 Article 130 of The Mental Health (Northern Ireland) Order 1986 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.

Expectations - Accountability

1.3 Performance management data supports the safe delivery of custody.

Indicators

- Data (including custody throughput, demographics, adverse incidents, strip-searching and complaints) are routinely collated and analysed to identify trends, and used to inform organisational learning and improve outcomes for detainees.
- The PSNI has mechanisms in place to assure itself, the NIPB and the public that the use of force in relation to arrest, detention and custody is safe and proportionate.
- Quality assurance processes promote the safe and respectful treatment of detainees and continuing professional development of staff.
- Effective mechanisms are in place to learn from adverse incidents and to identify and share good practice within and across police forces and partnerships.

References

ICCPR 10 (1)
ECHR 3
UNCAT 10, 11, 12, 13, 16
CCLEO 2, 3
BOP 1, 4, 7
BPUF 1, 15

1.4 The PSNI is meeting its obligations under Section 75 of the Northern Ireland Act (1998) and the public sector equality duty. The PSNI promotes respect for people from all backgrounds and with diverse needs and raises awareness of the discrimination that can be faced by particular groups.

Indicators

- There is effective and regular monitoring in place, including analysis of data on custody throughput by the Section 75 nine equality categories⁸¹.
- Assessments are conducted across detention and custody operations, including an element of external challenge to identify whether services deliver fair and equal treatment.
- An equality governance and accountability framework is established, linked to the PSNI's risk register. It includes:
 - collection of core data sets by the nine equality categories (as below) including strip-searching/use of force; and
 - arrangements for periodic reviews of the data with the PSNI's Independent Advisory Group and/or relevant local community groups plans to make improvements to practice where this is identified as being necessary appropriate leadership and governance structures to oversee and make sure the work is carried out.

81 Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.

- Staff can demonstrate their understanding of the disproportionate outcomes for the nine equality categories in the criminal justice system. Where staff come across unfair or discriminatory treatment they are able and required to take action in challenging, eliminating and reporting it (see section 3).
- Results of equality monitoring, and any other monitoring required for Section 75, are communicated to all staff and staff understand how they can implement and monitor appropriate action.
- Staff have been trained to recognise and meet the needs of people who have one or more of the Section 75 characteristics under the equality legislation. There are policies and procedures in place to ensure staff understand their obligations under Section 75.

References

CERD 2, 5 (a), 6
CEDAW 2, 15
DEDRB 2
DRM 4
DHRIN 5
CCLEO 2
BOP 5

1.5 The PSNI facilitates access as required for effective external scrutiny.

Indicators

- The PSNI responds to issues and complaints raised by Independent Custody Visitors (ICV). This includes dealing with immediate complaints and issues raised during visits.
- ICV feedback is used appropriately by the PSNI and there are regular and formal opportunities for the ICV scheme to raise issues with senior officers.
- The Chief Officer Group reports routinely to the NIPB on custody, including relevant management information and data. This includes the use of force and equality and diversity information.

References

OPCAT 19, 20, 21, 22
UNCAT 10, 11, 12, 13
BOP 4, 5, 7, 9, 29
BPUF 1, 15

Expectation - Partnerships

1.6 Partnership arrangements effectively support the identification and management of risks to the welfare of vulnerable detainees (including children) in police custody.

Indicators

- There is constructive engagement with all relevant partner agencies (including the Safeguarding Board for Northern Ireland, Northern Ireland Adult Safeguarding Partnership, Public Health Agency, Health and Social Care Trusts and the Health and Social Care Board, the Office of Social Services, the Youth Justice Agency, criminal justice agencies, Prisoner Escorting and Court Custody Services (of the Northern Ireland Prison Service), immigration authorities, ambulance service, etc.) to protect and divert children and vulnerable adults from custody, where possible, and to support the safe and respectful delivery of custody. Outcomes can be clearly demonstrated.
- Partners have agreed shared aims and objectives to support vulnerable adults and children to avoid detention in custody and criminalisation, wherever possible.

References

ICCPR 10 (1)
CRC 3, 37, 40
CCLEO 2, 6
PPMI 1, 2, 20
BOP 1

SECTION 2: PRE-CUSTODY: FIRST POINT OF CONTACT

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

Expectation - Assessment at first point of contact

2.1 From the first point of contact with the police service, officers and staff are alert to, identify and make effective assessments of risk and vulnerability and divert individuals, whose detention might not be appropriate, from custody.

Indicators

- All Police Officers and staff are trained in the needs of people with vulnerabilities and have access to training to improve decision making on diversion, detention, custody provision and their own practice.
- All Police Officers and staff who have contact with children recognise them as vulnerable by virtue of their age.

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- Call handlers and dispatchers provide relevant information in a timely manner to assist officers in assessing an individual's risk and vulnerability.
- There are systems and protocols in place to support Police Officers and staff in identifying individuals with known vulnerabilities and relevant history.
- There are evidence-based assessment approaches used by all Police Officers and staff to help them respond effectively to an individual's risk and/or vulnerability.
- Police officers and staff apply the principles of the Mental Health (Northern Ireland) Order 1986 and associated 'GAIN Guidelines on the use of the Mental Health (Northern Ireland) Order 1986' and the Northern Ireland Adult Safeguarding Policy '*Adult Safeguarding: Prevention and Protection in Partnership*' in their decision-making where appropriate (see sections 3 and 4).
- Police Officers divert vulnerable people, including children, away from custody when appropriate (see sections 3 and 4).
- Police Officers are familiar with and use alternatives to custody.
- Detainees in need of mental health care who are restrained for their own or others' safety are treated as a medical emergency. Police Officers and staff have easy access to mental health guidance and a mental health practitioner.
- All Police Officers and staff are trained in and use effective de-escalation techniques.
- All Police Officers and staff are trained in the safe use of restraint techniques and any use of force is recorded (see section 4).
- Police Officers communicate all relevant information to custody staff to contribute to the risk assessment process (see section 3).
- The PSNI has systems in place to ensure that transport used for detained individuals is safe and appropriate.

References

ICCPR 10 (1)
UNCAT 10, 11, 12, 13 16
CRC 3, 37, 40
CCLEO 2, 3, 6
BOP 1, 29
BPUF 1, 4, 5, 18, 19, 20
PPMI 1, 2, 20

SECTION 3: IN THE CUSTODY SUITE: BOOKING IN, INDIVIDUAL NEEDS AND LEGAL RIGHTS

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

Expectations - Respect

3.1 Detainees are treated with dignity and their diverse needs, while in custody, are met.

Indicators

- Police Officers and staff interact with detainees courteously and all detainees are treated with dignity from the first point of contact.
- Detainees are able to disclose confidential information, and any situation or condition that makes them vulnerable, in private.
- Police Officers and staff listen to detainees and are alert to and understand the impact of detention, particularly for those detainees identified as vulnerable. Effective support to cope with their detention is provided.
- Police Officers and staff engage positively with detainees during their detention, particularly those who are vulnerable and high risk.

References

ICCPR 10 (1)
CCLEO 2, 6
BOP 1
PPMI 1, 20

Expectations - Meeting individual and diverse needs

3.2 Staff show an understanding of equality and diversity and know how to respond to the specific needs relating to:

- **women;**
- **different racial groups;**
- **physical disability and intellectual impairment (learning disability);**
- **religious groups;**
- **older people;**
- **sexual orientation; and**
- **transgender identity.**

There are arrangements that enable these detainees to be treated according to their individual needs.

Indicators

- There is provision for detainees to access information in a language and format they can easily understand, for example, easy read format, Braille and DVD. Detainees are helped with clear explanations by staff when needed (see expectation 3.4).
- There are sufficient female custody staff members and appropriate facilities to respond to the welfare needs of detained women. Women are strip-searched only in the presence of two competent female staff.
- Custody staff are equipped to assess mental capacity and to identify detainees with intellectual impairments (learning disabilities) to ensure that effective safeguards are appropriately implemented.

- There is an adequate range of facilities and adaptations for disabled detainees and staff know how to use them.
- Staff have a good understanding of the needs that can arise from diverse groups and are aware that they should, for example:
 - appropriately respond to detainees' religious observations;
 - search detainees in a manner that is sensitive to their culture and religion and which takes account of their gender/transgender; and
 - recognise the distinct needs of older detainees, such as signs of mental and physical health problems and the onset of dementia and any safeguarding issues.
- Inappropriate language and behaviour, if it occurs, is addressed by staff and there is strong leadership to enable a culture of challenge in relation to this.
- Homophobic and other derogatory language and behaviour is not tolerated.
- There are effective arrangements to raise the awareness of staff to positively respond to the needs of transgender people.

References

ICCPR 10 (1)
ICESCR 12
CEDAW 2, 15 (1)
CERD 2, 5(a), 6
CRPD 1, 2, 3
DEDRB 2, 4
BOP 1, 5, 13
PPMI 1, 2, 20

3.3 Detainees of all nationalities are treated according to their individual needs.

Indicators

- Detainees are provided with information about the reason for their detention and, where necessary, have their immigration status and procedures in relation to that status explained in a language/format they can understand.
- Detainees can access the relevant Consulate, Embassy or High Commission where necessary.

References

ICCPR 9 (2), 10 (1)
ECHR 5, 6 (3)
DHRIN 5 (c)
BOP 1, 10, 13, 14, 16 (2)

3.4 The needs of detainees who experience difficulties communicating are met.

Indicators

- Staff have access to accredited translation and interpreting services wherever accuracy or confidentiality is important.
- Telephone translation is conducted using equipment that enables effective communication in reasonable privacy.
- Legal rights and entitlements and other relevant documents are provided in a range of formats and languages which reflect the population in Northern Ireland.

References

ICCPR 14 (3)
ECHR 6 (3)
DHRIN 5 (c)
BOP 14

Expectation - Risk assessments

3.5 All detainees are held safely and any risk they pose to themselves and/or others is competently assessed and kept under review.

Indicators

- Detainees are not made to wait outside the police station in vehicles. There is an ongoing risk assessment of all detainees where there is a delay in booking in.
- Staff know how to effectively assess and respond to any risk detainees pose to themselves and/or others.
- Staff use all existing up-to-date information about a detainee to complete any risk assessment.
- All staff demonstrate awareness and understanding of the different ways in which detainees may present mental health problems and other vulnerabilities and respond appropriately.
- Care plans reflect risk, and assessments are ongoing and are reviewed throughout the period of detention.
- Staff have knowledge and understanding of self-harm and how to support detainees at risk of harming themselves or others.
- Staff understand the purpose and importance of regular monitoring and rousing, particularly for those under the influence of drugs or alcohol.
- Handovers involve all custody staff where possible, are recorded and conducted in private, and result in the accurate sharing of relevant information.

References

ICCPR 10 (1)
ICESCR 12
CCLEO 2, 6
BOP 1
PPMI 1, 20

Expectations - Individual legal rights

3.6 Detention is appropriate, authorised and lasts no longer than is necessary.

Indicators

- Detention is authorised by custody officers who understand and recognise the needs of people with vulnerabilities and make decisions which take these needs into account.
- Alternatives to custody are considered and used when appropriate.
- Appropriate grounds for detention are established and recorded.
- Information on vulnerability and associated risk factors is communicated between custody officers and investigation teams to inform decisions on the prioritisation and progression of cases.
- Cases are progressed to allow detainees to be released or transferred at the earliest opportunity.
- In the case of immigration detainees there are effective arrangements with Home Office Immigration Enforcement to ensure alternative disposals are expedited.

References

ICCPR 9, 10 (1), 14

ECHR 5, 6 (3)

BOP 9, 10, 11, 12, 13, 14, 15, 16, 38, 39

3.7 Detainees understand and receive their rights while in police custody.

Indicators

- All detainees receive and are helped to understand their rights and entitlements. Any delay in being able to exercise this entitlement is authorised.
- Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts and that someone can be contacted as soon as possible.
- All detainees, including immigration detainees, are able to speak with legal representatives in private, free of charge and as soon as possible. If detainees decline the right to speak to a legal representative, the reasons for this are recorded.
- Detainees are not interviewed while under the influence of alcohol or drugs, or if medically unfit, unless exceptional circumstances prevail.
- Detainees are informed of the reasons for their arrest and continued detention during the review of the necessity to detain, and this is clearly recorded.
- Detainees or their legal representatives are able to obtain a copy of their custody record.
- Staff explain to detainees, in a language they can understand, documents that have important consequences or that concern their right of appeal.
- Detainees are informed of the PSNI retention and disposal policy for DNA.

References

ICCPR 9, 10 (1), 14 (3)
ECHR 6 (3), 8
BPRL 1, 5, 6, 7, 8
BOP 9, 10, 11, 12, 13, 14, 15, 16, 17, 18

Expectation - PACE Reviews

3.8 PACE reviews should be conducted in the best interests of the detainee to ensure that ongoing detention is necessary.

- PACE reviews are conducted in a timely fashion and focus on safeguarding the interests of the detainee and progression of the case.
- Police, where possible, conduct reviews of detention of a person who is vulnerable, including children, in person.

References

CRC 3, 40
CCLEO 2
BOP 9, 11

Expectation - Access to swift justice

3.9 Detainees have access to swift justice, with appropriate mechanisms for ensuring regular review of pre-charge bail conditions. Bail conditions are proportionate, legitimate and necessary to manage the risks posed by the suspect.

Indicators

- The PSNI finalises investigations during the first period of detention wherever possible. Where bail is used, the PSNI has an investigation plan and management regime in place to monitor the progress of the investigation to ensure timely completion of actions. This is documented.
- Where the period of bail exceeds 28 days, the PSNI applies the following approval process:
 - beyond 28 days - the approval of an appropriate Inspector⁸² is sought;
 - beyond three months - the approval of an appropriate Inspector is required; and
 - beyond six months - the approval of a Superintendent is required.
- These are minimum authority levels, although ranks may be exceeded.
- Bail conditions are necessary and proportionate to the risk posed by the detainee. Conditions are manageable and any restrictions placed on the detainee can be justified. The PSNI keeps all bail conditions under review so that they take account of any changes to the perceived risk posed by detainees.

82 As per PSNI Service Instruction SI0219, *Bail*, March 2019 this should be a Detective Inspector for detective led investigations, a Community Policing Team or Volume Crime Support Team Inspector for Community Policing Team or Volume Crime Support Team investigations, Gatekeeper Inspector for investigations where the gatekeeper has been consulted on other matters or the Duty Inspector for all other cases.

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- There is a reviewing officer to provide oversight and to establish the need for bail. The reviewing officer checks whether enquiries have been conducted expeditiously, whether there is supervisory oversight and establishes the risk to witnesses, the community, etc. with the officer in charge.
- The bail period is proportionate to the investigation still to be completed. It is realistic and in line with the lead time for other agencies and departments.

References

ICCPR 9, 14
ECHR 5, 6
BOP 9

Expectation - Complaints

3.10 Detainees know how to make a complaint and are enabled to do so before they leave police custody.

Indicators

- Detainees are told how to complain and are provided with relevant information.
- Complaints are taken and recorded before detainees leave custody.
- Detainees' complaints are investigated fairly and swiftly and are monitored, with any significant concerns addressed and outcomes recorded.
- Detainees are not disadvantaged because they have made a complaint.
- Detainees are not disadvantaged as a result of speaking to CJI or the RQIA Inspectors or custody visitors. Custody visitors inform CJI or RQIA Inspectors of any repercussions for detainees outside inspections.

References

OPCAT 19, 21
BOP 13, 14, 29, 33

SECTION 4: IN THE CUSTODY CELL, SAFEGUARDING AND HEALTH CARE

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody.

Expectation - Physical environment

4.1 Detainees are held in a custody suite that is and feels safe, and in a good state of repair.

Indicators

- All cells are equipped with working call bell systems that cannot be permanently muted. Staff explain to detainees how to use the call bell and activations are responded to promptly.
- Cells and communal areas are clean, free from ligature points and graffiti, of a suitable temperature and well ventilated. Staff carry out daily cell checks to maintain these standards and records are maintained and monitored.
- There are adequate arrangements in place for daily cleaning, removing any biological hazards, regular deep cleaning, and prompt repair of any defects.
- There is written guidance on the use of cells with restricted natural light and facilities.
- Staff can safely evacuate the custody area in the event of an emergency and evacuations are regularly practiced and recorded.
- All equipment (including the resuscitation kit) is appropriate, ready for use and regularly checked and maintained (see 'Expectation - Governance').
- All staff understand how to access and use the emergency equipment effectively (see expectation 4.8).

References

ICCPR 10 (1)
ICESCR 12
CCLEO 2, 6
BOP 1, 6

Expectation - Safety: Use of force

4.2 Any force used from first point of contact is strictly necessary, proportionate and lawful, used as a last resort and subject to robust accountability. It is carried out by trained staff using approved techniques.

Indicators

- All staff are trained in and use effective de-escalation techniques.
- Where force is used, staff only use approved techniques in line with their training, with no more force and for no longer than is necessary.
- Staff can demonstrate awareness of risks associated with particular forms of restraint and of how these risks can be minimised. When force is used detainees are examined

- by an appropriately qualified health care professional if requested, or if there are health care concerns.
- Use of force prior to arrival and 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.
 - Tasers are only used in exceptional circumstances, when there is a clear threat or danger. In addition:
 - the PSNI has a policy on their use;
 - custody staff are aware of their existence and application in custody;
 - Tasers are only authorised after a risk assessment;
 - Tasers are not used to gain compliance; and
 - Tasers are never used in drive stun mode.
 - Strip-searching is conducted only when absolutely necessary. It is appropriately authorised, carried out in private by members of staff of the same gender (in the presence of an appropriate adult if required), and is monitored at a senior level to ensure appropriate use.

References

ECHR 3
UNCAT 10, 11, 12, 13
CCLEO 2, 3
BPUF 1, 4, 5, 6, 18, 19, 20
PME 1

Expectation - Detainee care

4.3 Detainees are held in a safe and suitable environment, and their care needs are met.

Indicators

- Detainees are offered sufficient food and drink.
- Detainees are able to be clean and comfortable, with alternative clothing available while in custody.
- Detainees are offered outside exercise and suitable reading materials. Children and other vulnerable detainees are provided with the opportunity to have visits by family members and/or appropriate agencies that can provide support.

References

ICCPR 10 (1)
CRC 3, 37, 40
CCLEO 2, 6
PPMI 1, 2, 20

Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk).

Expectations - Safeguarding

4.4 Detainees are protected from harm and neglect. They receive effective care and support.

Indicators

- Staff are trained in safeguarding and have the knowledge required to protect vulnerable groups in their care, including arrangements for contacting appropriate adults and making suitable referrals to partner agencies.
- Current government and local guidance about safeguarding children and adults is accessible and safeguarding procedures are known and used by all staff.
- Those responsible for the welfare of detained children are informed of a child's detention and the grounds for detention at the earliest opportunity.

References

ICCPR 10 (1)
CCLEO 2, 6
BOP 1, 16 (3)
PPMI 1, 2, 20

4.5 An independent appropriate adult scheme for children and vulnerable adults is in place, operates to relevant national standards and is used.

Indicators

- The PSNI works actively with local partners to ensure the provision of independent and effective appropriate adults for vulnerable adults.
- The parents or guardians of those under 18 are used whenever they are willing, able and suitable for the role of appropriate adult. They are given written guidance on the role and are encouraged to actively protect the child's rights.
- There are no delays in securing an appropriate adult and they are available 24 hours a day.
- Adequate facilities are available to ensure that appropriate adults can speak to children in private and to sit with them if the adult considers this necessary to ensure the welfare of the child.
- The PSNI collects data in relation to the provision of appropriate adults, including who performed the role (for example, parents/guardians, youth justice staff or social worker). The data includes waiting times and the aspects of the process for which the adult was present. They are collated and analysed to assess whether the service is meeting the needs of children and vulnerable adults.
- Staff receive regular safeguarding training and know how to implement the agreed safeguarding procedures.
- Any child suspected of committing a criminal offence is treated under safeguarding procedures and appropriate authorities are notified immediately (see section 1).
- Custody officers ensure that concerns (for example, disclosure of abuse, welfare concerns) are referred to the appropriate agency in accordance with multiagency arrangements for safeguarding and as part of their in-custody and post-release assessment (see section 5).

References

ICCPR 10 (1)
CRC 3, 37, 40
BOP 1, 16 (3)
PPMI 1, 2, 20

4.6 Safeguarding issues concerning children are identified at the earliest opportunity, including at the first point of contact (see section 2).

Indicators

- Children are diverted from custody where possible.
- When force is used children are always examined promptly by an appropriately qualified health care professional.
- Staff understand and respond to the distinct needs of children. They recognise levels of maturity and how physical, sexual and emotional abuse and exploitation might affect a child's behaviour and any subsequent decisions taken about their care and welfare.
- Risk assessments are based on all relevant information. Particular attention is given to recognised risks associated with:
 - 'Looked After' children;
 - disabilities, including intellectual impairment (learning disabilities), communication difficulties, health conditions and substance misuse;
 - a previous history of abuse; and
 - those in custody for the first time.

References

CRC 3, 37, 40
UNCAT 10, 11, 12, 16
CCLEO 2, 6
PPMI 2

4.7 Children are not held in custody overnight, except as a last resort.

Indicators

- Children are kept separate from those who might pose a risk to them. Where it is safe to do so, children are not held in cells.
- Children are returned home to their parent/guardian. Where this is not possible and/or there are safeguarding concerns, there are effective arrangements with children's services in the local Health and Social Care Trust that cover the provision of accessible safe accommodation for children.
- Children are kept safe in custody.
- Girls under the age of 18 are allocated and informed of the identity of a named female officer who is responsible for meeting their welfare needs while detained.
- Only age-appropriate approved restraint techniques are used for children. Pain compliance techniques are never used on children.
- No child is subjected to a strip search unless it is intelligence-led, authorised by an officer of Superintendent rank and conducted in the presence of an appropriate adult.

References

CRC 3, 37, 40
UNCAT 10, 11, 12, 16
CEDAW 2
CCLEO 2, 3
BPUF 5

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

Expectation - Governance of health care

4.8 Detainees are cared for by health care practitioners and substance misuse workers, who have the appropriate skills and training, in a safe, professional and caring manner that respects their decency, privacy and dignity.

Indicators

- The requirement for health services for detainees in police custody is assessed and the services provided are appropriate for the need.
- Clinical governance arrangements include regular meetings between providers and commissioners, robust incident management, a confidential complaints process, monitoring of response times for all health services and patient outcomes and processes to share lessons learned from complaints and incidents.
- Detainees are treated by health care practitioners who receive ongoing training, supervision and support to maintain their professional registration and development.
- Health care practitioners have the skills, knowledge and competencies to meet the health care needs of all detainees.
- Health care practitioners and substance misuse workers are sensitive to detainees' situations and diverse needs and have access to professional language interpretation.
- Information sharing protocols exist with appropriate agencies to ensure efficient and confidential sharing of relevant health and social care information.
- Clinical examinations are conducted confidentially unless risk assessment suggests otherwise.
- Clinical rooms provide conditions that maintain decency, privacy and dignity.
- Clinical rooms comply with current infection control standards.
- There is at least one room that is appropriate for taking forensic samples and it is forensically clean.
- Detainees can see a health care practitioner of the gender of their choice on request. There are arrangements for a chaperone to be present if required.
- Providers of health services have registered with the relevant regulatory authorities as required.

References

ICESCR 12
CEDAW 12
CCLEO 2, 6
BOP 1, 24
PPMI 2, 20
PME 1

Expectations – Patient care

4.9 Detainees are asked if they wish to see a health care practitioner, are able to request to see one at any time for both physical and mental health needs, and are treated appropriately in a timely manner.

Indicators

- Consent is sought from detainees for health care interventions and health care professionals apply the principles of the Department of Health Social Services and Public Safety Northern Ireland (DHSSPSNI) Guide to Consent for Examination and Treatment March 2003 during this process.
- Each detainee has a single clinical record containing an up-to-date assessment, and any care plan conforms to professional guidance from authoritative sources. The Section 75 details of the detainee are also recorded.
- The use and storage of clinical records complies with contemporary good practice.
- Any contact with a doctor or other health care professional is recorded in the custody record and relevant information is shared with custody staff, including any medication provided or required.
- The results of any clinical examination are made available to the detainee and, with the detainee's consent, his/her legal representative.
- Treatments are appropriate to the clinical needs of the detainee and are in line with national guidance.
- Health care professionals liaise with other agencies, as necessary, to ensure continuity of care.

References

ICESCR 12
CCLEO 2, 6
BOP 1, 24
PPMI 1, 2, 20
PME 1

4.10 Detainees receive prescribed medication if needed and, subject to validation, detainees can continue with previously prescribed medications.

Indicators

- Detainees are prescribed medication to treat any clinical signs, symptoms or conditions.
- Detainees receive medication to provide relief for drug and alcohol withdrawal symptoms if clinically indicated, and can continue community prescribed opiate substitution treatment in custody, subject to validation.
- Prescribed medication is administered by competent staff members and is received at the designated times. Appropriate records are made of the receipt of medications.
- Detainees who are due prescribed medication and are being transferred to court custody receive their medication while at court.
- All medications on site are stored safely and securely, and are disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

References

ICESCR 12
CCLEO 2, 6
BOP 1, 24
PPMI 1, 2, 20
PME 1

Expectation - Substance misuse

4.11 All detainees have access to timely drug and alcohol services that meet their needs.

Indicators

- A service is provided to all drug and alcohol users.
- The substance misuse service affords access to the range of care services.
- Any contact with a drug or alcohol worker is recorded in the custody record.
- Detainees are made aware of how to access harm minimisation supplies on release.

References

ICESCR 12
CCLE 2, 6

Expectation - Mental health

4.12 Detainees have prompt access to mental health practitioners who are able to assess their clinical needs, divert/refer to mental health services and/or advise on treatment as necessary. Police custody, unless in exceptional circumstances, is not used as a place of safety for Article 130 Mental Health (Northern Ireland) Order (1986) assessments.

Indicators

- Police officers and staff receive regular training on mental health and learning disability issues, including identification of such issues and how to support detainees who are experiencing problems.
- Local arrangements with the relevant mental health services team of the local Health and Social Care Trust and ambulance service ensure that timely services are provided to people in urgent need of specialist mental health care, including prompt assessment of those detained on Article 130 of the Mental Health (NI) Order 1986.
- Detainees with severe mental health issues have prompt access to mental health professionals where indicated.
- Mental health professionals signpost detainees to and liaise with other relevant agencies to ensure continuity of care, including prison mental health services if required.
- Response times for Mental Health Order assessments and transfers to mental health facilities are monitored.

References

ICESCR 12
CCLEO 2, 6
BOP 1, 24
PPMI 1, 2, 20
PME 1

SECTION 5: RELEASE AND TRANSFER FROM CUSTODY

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

Expectation - Pre-release risk assessment

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

Indicators

- Good quality pre-release risk assessments are completed with the detainee: they are documented and identify any risks and vulnerability throughout their period of detention.
- Action is taken to reduce any risks and welfare concerns prior to release.
- Appropriate relevant information about risk, vulnerability or safeguarding is communicated to relevant agencies and support organisations.
- Particular attention is given to safely managing the release of vulnerable detainees.

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- There is up-to-date information, including contact details for support organisations, and this is provided to detainees in a format and language they can easily understand.
- Person escort records are completed clearly and accurately with all relevant detail, especially any issues relating to risk or self-harm.

References

ICCPR 10 (1)

CCLEO 2, 6

BOP 1, 13

PPMI 1, 2, 20

Expectation - Courts

5.2 Detainees who have been arrested on warrant, or who have been charged and refused bail, appear at court promptly either in person or via video link.

Indicators

- Detainees appear in court in a timely manner and are not held in police custody for longer than is necessary.
- Detainees who are being transferred to another custody facility or court are escorted safely and with consideration to their individual need.
- Detainees appearing at court in person and via video link are suitably dressed.
- Detainees who appear at court via video link are held in police custody for no longer than necessary after the hearing has concluded.

References

ICCPR 9, 14

ECHR 6

BOP 36, 37, 38, 39

GLOSSARY OF ACRONYMS

International Human Rights Instruments

Legally binding

CEDAW Convention on the Elimination of All Forms of Discrimination against Women, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46 (entered into force Sept. 3, 1981).

CERD Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195 (entered into force January 4, 1969).

CRC Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989) (entered into force September 2, 1990).

CRPD Convention on the Rights of Persons with Disabilities, adopted by the General Assembly, 24 January 2007, A/RES/61/106.

ICCPR International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force March 23, 1976).

ICESCR International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (entered into force January 3, 1976).

OPCAT Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 (entered into force 22 June, 2006).

UNCAT Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)] (entered into force June 26, 1987).

Normative

BOP Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (No. 49) at 298, U.N. Doc. A/43/49 (1988).

BPRL Basic Principles on the Role of Lawyers, Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, 27 August to 7 September 1990, U.N. Doc. A/CONF.144/28/Rev.1 at 118 (1990).

CCLEO Code of Conduct for Law Enforcement Officials, Adopted by General Assembly resolution 34/169 of 17 December 1979.

DEDRB Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief Proclaimed by General Assembly resolution 36/55 of 25 November 1981.

DHRIN Declaration on the Human Rights of Individuals who are not Nationals of the Country in which they live, adopted by the General Assembly resolution 40/144 of 13 December 1985.

DRM Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities Adopted by General Assembly resolution 47/135 of 18 December 1992.

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, G.A. res. 37/194, annex, 37 U.N. GAOR Supp. (No. 51) at 211, U.N. Doc. A/37/51 (1982).

PPMI Principles for the protection of persons with mental illness and the improvement of mental health care. Adopted by General Assembly resolution 46/119 of 17 December 1991.

Regional Human Rights Instruments

Legally binding

ECHR European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11 (Rome, 4.XI.1950).

APPENDIX 2: METHODOLOGY

Desktop research and development of inspection Terms of Reference and question areas

Research literature and guidance documentation was reviewed in relation to police custody. A Terms of Reference was developed, based on that used for the previous inspections of police custody (see Appendix 3). The *Expectations for police custody* were adapted for use in Northern Ireland, in consultation with the RQIA, and agreed with the PSNI. Other relevant documents included College of Policing Approved Professional Practice for Detention and Custody and inspection reports from other jurisdictions.

Study visit to Scotland and England

Assisted by relationships developed as members of the UK NPM the CJI Lead Inspector arranged to accompany partner Inspectorates on police custody inspections in England and Scotland. CJI accompanied Her Majesty's Inspectorate of Constabulary for Scotland (HMICS) on their inspection of Glasgow Custody Centre in January 2019 and they assisted by providing information on their methodology for undertaking reviews of custody records. In May 2019 CJI accompanied HMIP and HMICFRS on their inspection of Devon and Cornwall Police, visiting Exeter custody suite, observing custody record audits and thematic reviews and discussing the methodology for the custody record and use of force reviews.

Self-assessment and document review

The PSNI was asked to provide documents and data against the framework of the *Expectations*. A review was undertaken of the documentation provided to cross-reference information against the *Expectations*. This was used also to inform interview questions during the fieldwork phase.

Fieldwork

One-to-one and focus groups interviews were conducted with a range of personnel within the relevant agencies. Interviews were also conducted with stakeholders from across the voluntary and community sector. Representatives from the groups listed below were interviewed during the fieldwork which pre-dated the Covid-19 pandemic.

Detainee surveys

As in previous inspections, surveys were conducted of detainees who were currently on remand in Maghaberry Prison, Hydebank Wood Secure College, Ash House Women's Prison and Woodlands Juvenile Justice Centre and who had recently been held in police custody. The questionnaire developed for previous inspections was utilised to enable comparability with responses from the 2015 inspection.

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This covered all aspects of custody including the detainees' perspective on the treatment and conditions of their detention, individual rights under PACE and health care. The same questionnaire was used to seek information from detainees held in police custody during the visits to the custody suites. A total of 42 detainees completed questionnaires. The results compared to 2015 can be seen in Appendix 4.

Stakeholder consultation

Stakeholders who have an interest in or provide services to those held in police custody were consulted about their views regarding police custody. CJI Inspectors met with representatives from the following organisations:

- Belfast Health and Social Care Trust (provider of the Custody Health care service in Musgrave custody suite);
- Commissioner for Older People for Northern Ireland;
- Department of Health 'Looked After' Children and Adoption Policy Unit;
- Department of Justice Police Powers and Human Resources Policy Branch;
- Equality Commission for Northern Ireland;
- Forensic Medical Officer Administrative Lead for Belfast and Antrim;
- Health and Social Care Board;
- Her Majesty's Revenue and Customs;
- Home Office Immigration Enforcement;
- Hydebank Wood Secure College and Ash House Women's Prison;
- Law Society of Northern Ireland Criminal Solicitor's Committee;
- Woodlands Juvenile Justice Centre;
- Maghaberry Prison;
- Mindwise Appropriate Adult Scheme;
- Northern Ireland Commissioner for Children and Young People;
- Northern Ireland Human Rights Commission;
- Northern Ireland Policing Board Independent Custody Visiting Scheme (including focus group of Independent Custody Visitors);
- Office of the Lord Chief Justice;
- Office of the Police Ombudsman for Northern Ireland; and
- Prisoner Escorting and Court Custody Service.

Custody record reviews

Custody records relating to detainees entering police custody during October 2019 were sampled and reviewed as below. A list of 2,132 records was provided by the PSNI to CJI. From this records were selected in accordance with a sampling strategy developed by HMICS where a number of records were randomly selected proportionate to the throughput of each suite (in some cases insufficient throughput meant that all records had to be reviewed from one suite or that there was a shortfall in records) Reviews were conducted as follows:

- *Case Review Analysis*
 - 100 NicheRMS custody records reviewed; and
 - Overview of whole custody record (demographics, timings, PACE rights, health care, individual needs, risk assessment etc.).
- *Case Review Analysis - children*
 - Additional 37 cases reviewed involving child detainees;
 - Sampling strategy proportionate to throughput of each suite (insufficient numbers in two suites to cover thematic cases as well as Case Review Analysis); and
 - Questions limited to those relating to demographics, timings, bail and release.
- *Thematic Case Reviews - 40 NicheRMS custody records:*
 - Ten each of cases where the detainee was a) a child; b) intoxicated (through consumption of alcohol or drugs); c) was identified as having mental health issues; d) was subject to use of force during their time in custody; and
 - in depth review of demographics, timings, rights, risks, mental health assessments, child safeguarding, intoxication, diverse needs, immigration, use of force, PACE reviews and release.
- *Use of force CCTV reviews*
 - Review of 13 sets of CCTV footage (10 cases identified from use of force thematic cases, one case from the mental health thematic cases plus two additional cases from Case Review Analysis).

PSNI fieldwork

Visits were conducted to all custody suites which were open at the time of the inspection fieldwork in:

- Antrim;
- Banbridge;
- Coleraine;
- Dungannon;
- Lurgan;
- Musgrave (Belfast);
- Omagh; and
- Strabane (open temporarily due to the closure of Strand Road, Derry/Londonderry for refurbishment).

Enniskillen was closed pending re-building of the suite and Bangor was moth-balled at the time of the inspection.

During the visits CJI and RQIA Inspectors spoke to detainees, staff and service providers who were present including Custody Sergeants, Custody Detention Officers, health care professionals, members of the Appropriate Adult scheme, cleaning staff and solicitors.

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Interviews and focus groups were held with the following individuals and groups in addition to those spoken to during the fieldwork visits.

- ACC District Policing Command;
- Chief Inspector, District Policing Command;
- Chief Superintendent, District Policing Command;
- Crime Investigation Department focus group;
- Custody Detention Officers focus group;
- Custody Health Care Team, District Policing Command;
- Custody Inspector, Southern Area;
- Custody Sergeants focus group;
- Estates Services Business Unit;
- Health and Safety Branch;
- Inspector, District Policing Command;
- Local Policing Officers focus group;
- Sergeant, District Policing Command;
- Superintendent, District Policing Command; and
- Superintendent, Silver Lead for police custody, Musgrave custody suite.

APPENDIX 3:

TERMS OF REFERENCE

AN INSPECTION OF POLICE CUSTODY IN NORTHERN IRELAND

TERMS OF REFERENCE

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 OPCAT⁸³ (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 (UK) signed up to OPCAT in 2003. The UK 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 the RQIA are both designated bodies and therefore this inspection serves to assist in discharging responsibilities as part of the NPM.

Context

This is the third full inspection of police custody in Northern Ireland, which will consider the strategy, governance and delivery of custody by the PSNI. CJI and the RQIA published the first full inspection in 2009 with a follow-up review in 2012 then a further full inspection in 2016. These inspections have continued to identify ongoing issues with the governance and management of health care in custody.

At the time of the last inspection the PSNI were at the start of the 2020 custody change programme, which included changes to the governance and management of custody suites and the staff working within them, as well as rationalisation of the suites. As this programme nears its end the inspection will be timely in order to assess progress to date and identify any issues or risks for the programme as it reaches its conclusion.

83 Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, A/RES/57/199, adopted 18 December 2003; came into force 26 June 2006.

Aims of the inspection

The broad aims of the inspection are to assess the PSNI's performance against the police custody *Expectations* (see below) which set out the outcomes police forces are expected to achieve. The following five areas of the police custody will be inspected:

- Leadership, accountability and partnerships;
- Pre-custody: first point of contact;
- In the custody suite: booking in, individual needs and legal rights;
- In the custody cell, safeguarding and health care; and
- Release and transfer from custody.

Methodology

The inspection will focus on assessing the performance of the PSNI against the current (version 3, 2016, updated May 2018) *Expectations* for police custody. The expectations were developed by Her Majesty's Inspectorates of Prisons (HMIP) and Constabulary and Fire & Rescue Services (HMICFRS) in consultation with police and stakeholder organisations. The PSNI has been assessed against these expectations in the previous inspections and these enable CJI and the RQIA to inspect the PSNI against a common standard with police forces in England and Wales.

The *Expectations for Police Custody* sets out the framework and criteria used by the Inspectorates to assess police custody arrangements and the outcomes for those detained. They have been tailored for use in Northern Ireland (for example to reflect local legislation). The *Expectations* are independent but are informed by PACE (the Police and Criminal Evidence Act (1984)/Police and Criminal Evidence (Northern Ireland) Order (1989)) and their Codes, professional guidance to the police on detention and custody⁸⁴, and international human rights standards relevant to police custody⁸⁵. They are also drawn from inspection experience and wider consultation with stakeholders, including police forces and non-police groups. They incorporate learning from HMICFRS's thematic inspection of the welfare of vulnerable people in police custody⁸⁶ and from the cumulative experience of joint inspections of police custody to date. The *Expectations* for England and Wales were updated in May 2018, solely to reflect the requirements of the Policing and Crime Act 2017 in relation to bail and the introduction of released under investigation (see 'Access to swift justice'). As these requirements do not apply in Northern Ireland CJI will continue to use the bail requirements as set out in PACE.

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 The Police and Criminal Evidence (Northern Ireland) Order 1989.

84 *Authorised Professional Practice on Detention and Custody*, College of Policing, July 2015.

85 *Monitoring Police Custody – a practical guide*, Association for the Prevention of Torture, 2013.

86 Vulnerability is linked, in many cases, to a minority status that increases the risks of stigmatisation and ill-treatment. Individuals therefore may be vulnerable in a given context and not in another. *The welfare of vulnerable people in police custody*, HMIC, March 2015.

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The inspection will be undertaken at the same time as an inspection of court custody and escorting in Northern Ireland [*Post-ToR note - this inspection was delayed due to the updating of the *Expectations for court custody and escorting* by HMIP in 2019. This inspection will commence once these are published in 2020, Covid-19 restrictions permit and court sittings increased]. Information collected on the escorting of detainees from police custody to courts may be gathered during the course of this inspection and incorporated into the report on court custody and escorting.

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 provides updates on the progress of the PSNI custody change programme will be reviewed.

Delivery

Self-assessment

The PSNI will be asked to undertake a self-assessment based on the *Expectations* for police custody which will be reviewed by CJI prior to the commencement of the fieldwork.

Stakeholder consultation

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

- Belfast Health and Social Care Trust;
- Commissioner for Older Persons for Northern Ireland;
- Defence solicitors/Northern Ireland Law Society;
- Department of Health Office of Social Services;
- Department of Justice Police Policy and Strategy Division;
- Equality Commission for Northern Ireland;
- Health and Social Care Board/Public Health Agency mental health lead;
- Health and Social Care Trusts Unscheduled Care Emergency Department lead;
- Her Majesty's Revenue and Customs;
- Home Office Immigration Enforcement;
- Human Rights Commission for Northern Ireland;
- Mindwise (appropriate adult scheme);
- Northern Ireland Commissioner for Children and Young People;
- Northern Ireland Policing Board, including the Independent Custody Visiting Scheme;
- Representatives of the Judiciary;
- Office of the Police Ombudsman for Northern Ireland;
- Prison Service Reception Governors (Maghaberry Prison and Hydebank Wood); and
- Woodlands Juvenile Justice Centre.

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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 Wood Secure College and Ash House Women's Prison. The views of children in police custody or recently remanded to the Woodlands 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 the RQIA will plan a series of unannounced visits to custody suites during the fieldwork period.

A review of custody records from NicheRMS will be undertaken.

Feedback to agency

On conclusion of the fieldwork the evidence will be collated, triangulated and analysed and emerging recommendations will be developed. CJI and the 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 six 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.

APPENDIX 4:

DETAINEE QUESTIONNAIRE RESPONSES

Percentage relate to the proportion of detainees who answered 'yes' unless specified. 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 2015 the box has been greyed out. General information relates only to detainees surveyed (not to total detainees held by the PSNI).

	2019	2015
Number of completed questionnaires:	42	55
SECTION 1:		
General information		
2	Station held at:	
	Antrim	21% 15%
	Banbridge	10% 0
	Bangor	0 7%
	Coleraine	5% 9%
	Dungannon	7% 2%
	Enniskillen	0 5%
	Grosvenor Road	0 2%
	Lurgan	7% 7%
	Musgrave Street	36% 35%
	Omagh	7% 4%
	Strand Road (<i>responses for Strand Road are from those detainees surveyed in prison as the custody suite was closed during the visits</i>)	7% 15%
3	Are you under 21 years of age?	29% 51%
4	Are you transgender/transsexual?	0 0
5	Are you from a minority ethnic group? (Inc all those who did not select white British, white Irish or white other categories)	5% 2%
6	Are you a foreign national?	7% 7%
7	What, if any, is your religion:	
	None	14% 9%
	Presbyterian/Church of Ireland/Methodist/other Christian	31% 38%

	2019	2015
Number of completed questionnaires:	42	55
Roman Catholic	55%	53%
Non-Christian (Buddhist, Hindu, Jewish, Muslim, Sikh)	0	0
8 Are you homosexual/gay or bisexual?	5%	0
9 Do you consider yourself to have a disability?	19%	35%
10 Have you been in police custody before?	52%	71%
SECTION 2: Your experience of this custody suite/the last custody suite you were held in		
11 Were you held at the police station for more than 24 hours?	21%	43%
12 Were you told of your rights when you first arrived?	93%	76%
13 Were you told about PACE?	57%	56%
14 Were you given a tracksuit to wear?	76%	58%
15 Could you use the toilet when you needed to?	88%	96%
16 If you used the toilet, was toilet paper provided? (without asking)	50%	80%
16b Were you offered menstrual protection? (females only)	29%	-
17 Would you rate the condition of your cell as 'good' for:		
17a Cleanliness?	69%	60%
17b Ventilation/air quality?	64%	47%
17c Temperature?	55%	45%
17d Lighting?	81%	58%
18 Was there any graffiti in your cell when you arrived?	88%	11%
19 Did staff explain the correct use of the cell bell?	90%	62%
20 Were you held overnight?	81%	96%
For those held overnight:		
21 Were you given a pillow and a blanket?	86%	98%
For those who were held overnight and were given items of bedding:		
22 Were these clean?	79%	89%
23 Were you offered a shower?	24%	20%
For those held over 24 hours	33%	30%
24 Were you offered a period of outdoor exercise?	0	5%
For those held over 24 hours	0	13%
25a Were you offered anything to eat?	86%	93%
25b Were you offered anything to drink?	88%	98%
26 Was the offer of food and drink you received 'good'/'very good'?	36%	21%

		2019	2015
Number of completed questionnaires:		42	55
27	Was the food and drink suitable for your dietary requirements?	93%	88%
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	14%	24%
29	Were you offered anything to read?	12%	16%
30	Was someone informed of your arrest	87%	78%
31	Were you offered a free telephone call?	90%	69%
If you were denied a free telephone call:			
32	Was a reason given?	n/a	17%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	7%	11%
33b	Contacting your partner, relative or friend?	24%	33%
33c	Contacting your employer?	10%	4%
33d	Where you were going once released?	14%	36%
34	Were you offered free legal advice?	100%	89%
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	88%	65%
36	Were you interviewed by police about your case?	74%	69%
For those who were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	85%	97%
38	Was an appropriate adult present when you were interviewed?	100%	100%
39	Was an interpreter present when you were interviewed?	100%	100%
SECTION 3:			
Safety			
41	Did you feel safe?	88%	85%
42	Were you victimised by a member of staff?	5%	9%
43	If you felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	50%	40%
43b	Physical abuse (being hit, kicked or assaulted)	50%	100%
43c	Sexual abuse	0	0
43d	Your race or ethnic origin	0	0
43e	Drugs	0	0
43f	Because of your crime	0	0

		2019	2015
Number of completed questionnaires:		42	55
43g	Because of your sexuality	0	0
43h	Because of you have a disability	0	0
43i	Because of your religion/religious beliefs	0	0
43j	Because you are from a different part of the country than others	0	0
44	Were your handcuffs removed on arrival at the police station?	76%	90%
45	Were you restrained while in the police custody suite?	10%	15%
46	Were you injured whilst in police custody, in a way that was not your fault?	7%	11%
47	Were you told how to make a complaint about your treatment?	50%	35%
48	Were you treated well/very well by staff in the police custody suite?	81%	72%
SECTION 4: Health Care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	88%	94%
51	Were you seen by a health care professional during your time in police custody?	88%	94%
52	Were you able to see a health care professional of your own gender?	55%	78%
53	Did you need to take any prescribed medication when you were in police custody?	46%	56%
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	44%	67%
55	Did you have any drug or alcohol problems?	33%	31%
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?	25%	13%
57	Were you offered relief or medication for your immediate withdrawal symptoms?	0	27%
For those who were seen by health care:			
58	Would you rate the quality as 'good'/'very good'?	69%	65%
59	Did you have any specific physical health care needs?	26%	31%
60	Did you have any specific mental health care needs?	40%	37%
For those who had mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	13%	13%



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