national preventive mechanism

Police Custody

A follow-up review of inspection recommendations

February 2013

The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
a better justice system for all

Police Custody

A follow-up review of inspection recommendations

February 2013

Criminal Justice Inspection
Northern Ireland
a better justice system for all

Contents

Criminal Justice Inspection Northern Ireland (CJI) and the Regulation and Quality Improvement Authority (RQIA) are members of the UK's National Preventive Mechanism (NPM), a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.

List of abbreviations

ACPO	Association of Chief Police Officers
AFMONI	Association of Forensic Medical Officers in Northern Ireland
CDO(s)	Civilian Detention Officer(s)
CJI	Criminal Justice Inspection Northern Ireland
DNA	Deoxyribonucleic acid
DoJ	Department of Justice
FMO(s)	Forensic Medical Officer(s)
FSNI	Forensic Science Northern Ireland
GMC	General Medical Council
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
HOLMES	Home Office Large Major Enquiry System
HSC	Health and Social Care
NPIA	National Policing Improvement Agency
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PACE	Police and Criminal Evidence (Northern Ireland) Order 1989
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
SDHP	Guidance on the Safer Detention and Handling of Persons in police custody
UKBA	United Kingdom Border Agency

Chief Inspectors' Foreword

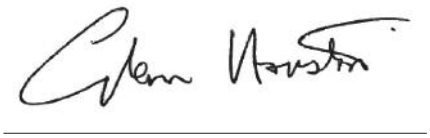
This is a follow-up review of inspection recommendations to our 2009 report, *'Police Custody: The detention of persons in police custody in Northern Ireland'*. The custody and care of some 27,000 detained persons represents a considerable challenge to the police. Often detainees present with challenging behaviours fuelled by alcohol and drug abuse, and many have underlying mental health issues.

The Police and Criminal Evidence Act 1984 (PACE) Codes of Practice and the Association of Chief Police Officers (ACPO) Guidance, and the Corporate Manslaughter and Corporate Homicide Act all place significant responsibilities onto police custody staff, many of whom are civilians employed on a managed services contract.

Of the original 12 recommendations only three have been achieved, six have been assessed as partially achieved and three have not been achieved. Custody services have, in general, been delivered to an acceptable standard, when compared to the criteria for assessment. However, the limited progress in respect of some recommendations, particularly in relation to the moving to a centralised model, and in achieving a consistency of service delivery across the custody estate, is disappointing. Inspectors also found shortcomings in relation to the storage and retention of out-of-date medication and forensic samples, both of which suggest inadequate supervision.

It is essential that all of the outstanding recommendations in respect of custody provision and healthcare are fully implemented. In view of the limited progress made to date, Inspectors plan to carry out a full inspection in the next financial year. We wish to express our thanks and appreciation to all those who spoke with Inspectors during the course of this follow-up review.

BRENDAN McGUIGAN
Chief Inspector of Criminal Justice
in Northern Ireland
February 2013



GLENN HOUSTON
Chief Executive
The Regulation and Quality Improvement Authority
February 2013

Criminal Justice Inspection
Northern Ireland
a better justice system for all

The **Regulation** and
Quality Improvement
Authority

Section 1

Follow-up review

CHAPTER 1:

Introduction

Background to the follow-up review

Inspections carried out by Criminal Justice Inspection Northern Ireland (CJI) and the Regulation and Quality Improvement Authority (RQIA), which relate to places of detention, contribute to the United Kingdom's response to its international obligations under the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies - known as the National Preventive Mechanism (NPM) - which monitor the treatment of, and conditions for, detainees. CJI and the RQIA are two of several designated bodies making up the NPM in the United Kingdom.

In June 2009 CJI published its first report on police custody, conducted with assistance from the RQIA. The inspection assessed the Police Service of Northern Ireland's (PSNI's) approach to police custody using a framework of expectations developed in England and Wales by Her Majesty's Inspectorates of Prisons (HMIP) and Constabulary (HMIC), which were adapted for use in Northern Ireland. The framework covered expectations in relation to strategic and service-wide issues; treatment and conditions of detainees; healthcare; and individual rights. Overall the report found that custody services were performed to an acceptable standard when compared to the criteria for assessment. Particular strengths were identified in undertaking a risk assessment and in dealing with individuals under the influence of alcohol and/or drugs.

The inspection however, identified several issues in the PSNI's delivery of custody. A number of these related to the provision of healthcare. Issues were also identified with staffing and training for the role of Custody Sergeant and the organisational arrangements to manage and support them. The report therefore made 12 recommendations for improvement. The purpose of this follow-up review is to assess progress and developments in implementing those recommendations. Inspectors also visited a number of custody suites across the police service in order to ensure CJI and the RQIA fulfil their NPM responsibility to regularly visit places of detention.

Changes since the 2009 inspection

In June 2009 the Northern Ireland Office published its own report, conducted at the request of the PSNI, specifically focussed on healthcare in police custody.[1] This raised some similar issues to the CJI/RQIA report and contained 15 recommendations, many of which supported the CJI/RQIA's proposals. The PSNI had also commissioned Deloitte to undertake a review of police custody and provide recommendations about the future of the custody estate and delivery of custodial services, which was in the draft stages at the time of inspection fieldwork.

Since the 2009 inspection a refurbishment programme had been undertaken to upgrade some of the older custody suites in line with current standards. A proposed move to a smaller number of 'super suites' had been reconsidered due to budgetary constraints. A revised plan had been developed to rationalise the estate and was in the process of being finalised during the fieldwork. A 50-

1 *'Review of healthcare provision in custody suites within the Police Service of Northern Ireland'*, Northern Ireland Office (2009).

cell facility had however been completed following the rebuilding of Musgrave Street station. The opening of 20 of these cells had therefore enabled the centralisation of provision in B District (East and South Belfast). There were plans to open further cells in Musgrave Street in the future and close the other remaining Belfast suite.

Since the 2009 inspection a project team had been identified which included a strategic lead (a District Commander), an operational lead (an Area Commander) and a project work stream co-ordinator (from the Performance Improvement Unit) who had drawn up project documentation with contributions from various functions related to custody. The project documentation outlined proposals for the implementation of a custody management team, cost savings identified, and monitoring and key performance indicator requirements for the future. Inspectors advised that decisions about the proposals were imminent with a view to changes being introduced to current custody delivery. Relevant information from these proposals as they relate to the recommendations will be outlined in Chapter 2.

The Corporate Manslaughter and Corporate Homicide Act was given Royal assent on 26 July 2007. The offence of corporate manslaughter in England, Wales and Northern Ireland ('corporate homicide' in Scotland) came into force across the United Kingdom on 6 April 2008. In June 2012 Minister of Justice, David Ford MLA, secured Assembly approval for all provisions of the Corporate Manslaughter and Corporate Homicide Act 2007 to extend to Northern Ireland. The offence of corporate manslaughter covers deaths in prison, police, court and immigration cells, and in facilities where individuals are detained or remanded for treatment under the Mental Health (Northern Ireland) Order 1986, as well as secure accommodation for young people. This therefore has implications for the PSNI's delivery of custody services.

New healthcare standards and legislation had also been introduced since the initial inspection which impacted on the provision of medical services in police custody suites. The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 came into operation on 1 October 2010. The regulations require each designated body, including Health and Social Care (HSC) Trusts, to nominate or appoint a Responsible Officer. Every doctor is required to have a named Responsible Officer. In November 2009 the General Medical Council (GMC) introduced arrangements through which every doctor wishing to remain in active practice in the United Kingdom is required to hold a licence to practice. This requirement extends to the work of Forensic Medical Officers (FMOs).

A second edition of the Guidance on the Safer Detention and Handling of Persons in Police Custody (the SDHP) published on behalf of the ACPO by the National Policing Improvement Agency (NPIA) had been produced earlier in 2012.[2] In addition the 'expectations' developed by HMIP and HMIC, outlining the criteria used to assess the treatment of, and conditions for detainees in police custody in England and Wales, had been updated and re-issued in 2012. These covered the four areas of strategy; treatment and conditions; individual rights; and healthcare.

Custody provision at the time of the follow-up review

At the time of fieldwork the PSNI had 126 cells open full-time (with an additional four open on a part-time basis). In addition, the new build at Musgrave Street had a further 30 cells which had not yet been opened. Inspectors were advised that the PSNI planned to move to a nine-suite model which would provide up to 153 cells. This included the building of an additional 40 cells across two locations, but this was depending on funding available. Several of the suites had been refurbished since the 2009 inspection report and the PSNI had plans to conduct further refurbishments. Two of the suites Inspectors visited were quite clearly in need of refurbishment.

In the financial year 2011-12 the PSNI held 26,904 people in police custody. This is a similar number to those held in the previous years (26,921 in 2010-11 and 27,907 in 2009-10). Of those held in 2011-12 the

2 '*Guidance on the Safer Detention and Handling of Persons in Police Custody*', second edition, NPIA on behalf of ACPO (2012). Available online at www.acpo.police.uk/documents/ criminaljustice/ 2012/ 201203 CJBAGoSDHoPPCv2.pdf.

majority were male (86%) and in the age group 18 to 24 years (32%) then in the age group 25 to 34 years (26%). Those aged under 18 years accounted for 10% of those detained. This was proportionately a reduction from the two previous years (11% in 2010-11 and 13% in 2009-10).

Since the 2009 inspection report the PSNI expanded the numbers of Civilian Detention Officers (CDOs) which were provided by an external contractor under a managed service contract for guarding and associated services. There were therefore, during the fieldwork week, no Police Officers performing the role of Police Gaoler, as in the initial inspection, and Detention Officers worked in every custody suite. The provider had given, under the contract, a specified number of CDOs across the custody estate, including a resilience pool to cover vacancies or absence due to leave, sickness etc. The PSNI had a contract manager for the whole of the managed service contract (which also included for example, security and guarding services). The CDO service had not, to date, been signed off as a 'managed service' but this was anticipated to be delivered under a new contract in 2013.

The follow-up review

The purpose of this review was to follow-up the extent to which the PSNI had implemented the recommendations made in the original 2009 report. As part of the fieldwork for this review, CJI and the RQIA conducted an examination of relevant project, policy and training documentation and statistical reports. Inspectors then undertook a series of follow-up interviews and focus groups, visiting a number of custody suites at various times and locations, where practice was observed and persons present were spoken to. The 2012 expectations for police custody developed by HMIP and HMIC were adapted for use in Northern Ireland and used to assess the treatment of, and conditions for, detainees. During the fieldwork Inspectors spoke with:

- CDOs;
- cleaners in custody suites;
- Community Psychiatric Nurses;
- Custody Inspectors;
- Custody Sergeants;
- detainees;
- defence solicitors;
- Drug Arrest Referral Team members;
- FMOs;
- Head of Custody Healthcare;
- Interpreters;
- Operational lead for custody; and the
- Strategic lead for custody.

The following chapter looks at each of the recommendations, the PSNI's response, and provides the Inspectors' assessment of progress. The final chapter draws conclusions about the progress to date, acknowledges the work that has taken place, and emphasises the need for work to continue in respect of custody provision to address the issues raised in the original inspection report.

CHAPTER 2:

Progress on recommendations

Recommendation 1

The PSNI should ensure that staff can access all relevant policy documents relating to police custody via a centralised location, including the SDHP, and that custody staff are aware of this facility and its importance (paragraph 2.5).

Status: Partially achieved

PSNI response

Action plan:
The PSNI has prepared a custody policy directive which is currently in draft form. The draft contains all current policies and procedures relevant to the safer detention of persons in custody. It also contains links to the SDHP and relevant legislation. The existence of the SDHP and its importance has been disseminated to custody staff and is also the cornerstone of custody training. All current policy documents are available via the PSNI intranet, and where applicable, hard copies have been provided to custody staff.

Latest position:
Recommendation completed - policy directive issued on 7 July 2009.

Inspectors' assessment

An excellent custody section of the PSNI intranet site (PoliceNet) had been developed containing a number of electronic documents for reference use by custody staff. This included the updated custody police directive, which contained links to procedures and guidance, policies and service procedures and risk assessment documentation. It also contained the SDHP and links to Officer Safety Bulletins, custody updates, links to the *'Learning the Lessons'* bulletins[3] and custody forms in various languages for use with detainees who did not speak English as their first language.

Inspectors found that there was a general unawareness of this area in PoliceNet by custody staff spoken to. They did however receive updated information by email from the Inspector responsible for custody policy, which they used their own methods to store for future reference. However one Sergeant advised that there were different mailing lists, therefore information was not always received by relevant staff. Another Sergeant attempted to locate the area of the site subsequent to the meeting with Inspectors but had to request a link to it from the policy representative as he found it difficult to locate. There is clearly an onus on individual Officers to take note of emails alerting them to such developments, but it would be helpful if future emails continued to direct staff to the site and therefore reinforced its existence and location.

3 *'Learning the Lessons'* bulletins are developed by the ACPO, the NPIA, the Independent Police Complaints Commission, HMIC, the Home Office, the Police Federation and the Police Superintendent's Association of England and Wales. The bulletins are published regularly to help the police service learn lessons from investigations and other operations of the police complaints and conduct system. See www.learningthelessons.org.uk.

Recommendation 2

Officers should be dedicated to the role of Custody Sergeant, and have priority access to places on the custody course and refresher training, as well as handover briefing time built into their working patterns (paragraph 2.10).

Status: Partially achieved

PSNI response

Action plan:
The Custody Officer role is included in the terms of reference in a review of custody carried out by an independent consultant. Current direction is that only trained Officers will be appointed to act in the capacity of Custody Officer. Custody Officers attend the (National) Safer Detention Custody Officer Learning and Development Programme (15 days) and the refresher course after two years (five days).

Latest position:
There is no set policy in place regarding dedicated Custody Sergeants. All Sergeants that undertake the role of Custody Sergeant have been trained in the role. Training branch have recommended once a year for refresher training, (refresher training has been planned, incorporating law, procedure, Personal Safety Programme and First Aid) this will need to be ratified by policy. However the NPIA are currently developing a template which will be released around September that will stipulate when/what will be required. Training branch are therefore waiting for this to be released before deciding on the best way forward. In the interim, Training branch are still providing refresher training when asked. Custody will not be a specialist role as there will not be a centralised custody unit, also backfill will be managed by other trained Sergeants within the district.

Inspectors' assessment

Most districts visited had identified four or five dedicated Custody Sergeants who worked a shift system designed to provide continuous cover in the custody suite. On occasions where there was additional cover required (for example, during sickness or holiday absence), a Response Sergeant may be allocated to cover custody duties. This practice however, appeared to Inspectors, in most locations, to be less frequent than in the previous inspection, and CJI were advised that Sergeants who provided cover in this way had attended the custody training course. Only one district did not have dedicated Custody Sergeants. In this district Response Sergeants spent half their shift in the custody role and then changed to response policing duties.

Custody Sergeants remained concerned about the risks of Response Sergeants working as Custody Officers who did not perform the role regularly and may not have undertaken custody duties for several months. The difficulty in keeping abreast of updates to custody practice and alert notices was highlighted as a particular problem for those who did not perform the role regularly.

There was no specific Custody Officer refresher training course in place at the time of inspection fieldwork. Custody Sergeants advised however, that they were able to access elements of refresher training via normal processes in relation to personal safety, first aid and the use of oxygen and the defibrillator (see below). Custody Sergeants spoken to also confirmed that they were able to undertake a handover with the previous Custody Officer at the start of their shift.

Additional information

Custody Sergeants suggested that it would be helpful to have a dedicated custody refresher training course which included issues relating to custody (for example, regarding risk assessment, new guidance and procedures etc.) in addition to the training required by law as outlined above. The SDHP suggests that *'mutual benefits can be achieved through joint agency training, for example, staff from mental health teams could deliver training to custody staff on dealing with detainees with mental ill health'*. Mental health was considered by all custody staff to be an area which they could benefit from further awareness training in. The Community Psychiatric Nurses situated in Musgrave Street custody suite could be extremely valuable in this regard, subject to agreement from their employing Trust.

Since the 2009 inspection report the PSNI had phased out Police Gaolers and replaced them with CDOs in all custody suites. Inspectors therefore considered the work of the CDOs in their inspection, including their staffing and training, as the introduction of the role impacted on the work of the Custody Sergeants. Custody Officers and Managers were extremely positive about the work of the CDOs and said they were a valuable resource who they believed to be competent and have a good rapport with detainees.

The CDOs had been recruited from a range of professional backgrounds; some with previous detention or security related experience (for example in policing or prisons) and some from entirely unrelated occupations (such as construction or retail). Concerns were raised with the training that CDOs received to prepare them for the role, which they believed was insufficient in relation to self-harm and mental health. Those spoken with stated that trainers tried their best, but they felt that their lack of experience in a custody role meant that the training focussed on elements that could be taught in the classroom rather than giving examples of realistic and practical situations faced when doing the job. The CDOs who did not have any prior experience of detention or security roles felt particularly vulnerable. By contrast attempts had been made to make the training for Custody Sergeants more practical. The Custody Officer training course had been extended to include case studies and role plays, which added a more practical element to the course and was felt to be beneficial. **Inspectors recommend that the training course for CDOs be reviewed and amended to provide staff with a more realistic preview of the role and more practical experience of situations likely to be faced in the custody suite.**

Recommendation 3

The PSNI puts in place organisational arrangements for the support of Custody Sergeants to ensure greater consistency in role and practice across the service (paragraph 2.17).

Status: Not achieved

PSNI response

Action plan:
The Custody Officer role is included in the terms of reference in a review of custody carried out by an independent consultant. Current direction is that only trained Officers will be appointed to act in the capacity of Custody Officer. Custody Officers attend the (National) Safer Detention Custody Officer Learning and Development Programme (15 days) and the refresher course after two years (five days).

Latest position:
All Custody Sergeants that perform the role must be trained and have attended the Custody Sergeants course. Refresher training has been recommended once a year, however this needs to be agreed and authorised via region. In the interim, Training are still providing refresher training when/where asked. To help ensure needs and demands of regional custody staff are met, it is being proposed that a number of workstreams are set in motion to streamline current working practices. As well as the aforementioned workstreams, the Regional Senior Management Team are working through the establishment of agreed protocols with other statutory bodies for key parts of the business, thereby providing a strategic corporate direction for all custody personnel. Also, a new tier of corporate governance has been established to manage and action future decisions and best practice for the whole of PSNI custody provision.

Inspectors' assessment

At the time of the follow-up review the Chief Officer lead for custody was the Assistant Chief Constable for District Policing Urban, and custody policy was located within district policing command. The governance for custody was provided by the Local Crime and Justice Board which was shortly to be subsumed into the Policing with the Community

Programme Board. Inspectors were advised that a decision on which Assistant Chief Constable would ultimately hold the portfolio for custody was imminent.

Agreement had been reached with District Commanders that individual performance reviews for custody staff would be determined centrally to increase consistency of practice and standards. The Review of Custody Project had produced a paper in October 2011 which included four options for the custody service model, ranging from Option 1 *'Do nothing - remain with current model'* to Option 4 *'A service-wide custody service branch model'*. Option 4 had been identified as the preferred long-term option for the PSNI. This would ultimately provide a fully centralised model comprising of custody business services management, custody policy and strategy management with ownership of custody staff. In the short-term, Option 3, comprising custody business services management and custody policy and strategy management but with custody staff remaining devolved to districts, had been identified as having merit.

A Custody Management Team Implementation Proposal had been developed to enable the Service to move towards Option 3 in the short-term. A work stream cost saving summary had also identified five areas of service provision where standardisation and simplification could result in improvement of custody operations as well as cost savings. For example, the PSNI has moved to a single provider for meals and drinks, and a single provider for clothing and footwear. Inspectors were advised that discussions were ongoing to progress to the service-wide custody service branch model over the longer-term.

Another area which had been identified as an opportunity to reduce costs was in laundry provision with a move to a new price structure and standardised practices. However, despite the *'go live'* date for this being 1 April 2012, inconsistencies were still observed in custody suites as to whether blood/urine stained blankets were either dry cleaned or discarded. Inspectors noted that detainee clothing was discarded after use. By the time of the follow-up review Inspectors would have expected that the cost effectiveness review would have been conducted on the disposal/laundering of blankets by various external contractors with a standardised approach being adopted to ensure the safe management and disposal of these items. The PSNI advised CJI that a standardised approach was currently being explored. The solution identified is the use of the current in-house cleaning provider to provide the laundry service. The Central Procurement Department have been contacted regarding the feasibility of extending the existing cleaning contract to perform this service, and at the time of inspection the PSNI were awaiting a decision.

In the absence of overall custody management structures at the time of fieldwork, Inspectors saw many examples of continuing inconsistency in custody practice across the estate. This is reflected particularly in the Inspectors' assessment of three of the recommendations made in the initial report, for example the approach to staffing custody suites with designated staff (see Recommendation 2 above), the approach to custody records (see Recommendation 4 below) and the management of medications (see Recommendation 10 below), as well as the issue highlighted above.

Other issues where differences were seen were, for example, in the provision of razors to detainees for shaving (in some suites this was on a risk assessed basis, in others there was a blanket ban on the use of razors) and the provision of toilet paper in the cell (again in some suites this was on a risk assessed basis, in others on request). In addition, there were inconsistencies in whether special considerations were made around the detention of females and juveniles.[4] In some suites there were specific cells designated for this purpose, or attempts were made to keep them separate from adult male detainees depending on space available. However, in others, there did not appear to be special considerations made about the location of female or juvenile detainees.

Whilst these may appear to be day-to-day operational issues, once combined with the more significant issues contained within the recommendations below, they

4 The SDHP states that *'custody management plans should clearly identify the rooms to be used to detain young persons'*. See 9.2 Detention Rooms and Cell, page 153.

illustrate a lack of consistency in practice which impacts on the day-to-day work of the Custody Officer and their staff.

On a day-to-day basis, Duty Inspectors were responsible for the oversight and supervision of custody. In Antrim there was a dedicated Custody Inspector who covered the two custody suites, the PACE Suite and the Serious Crime Suite for detainees arrested under the Terrorism Act (2000). Custody Sergeants advised that they were able to contact an Inspector when required to undertake reviews of detention at relevant times or to escalate problems which arose.

Additional information

As highlighted above CDOs provided under a managed service contract were based in all custody suites. The contract that was in place during the week of fieldwork for the follow-up review was for security guarding and associated services and had been running since 2009. Under this contract CDOs were provided over and above the requirements of the initial contract and therefore this was not a fully managed service contract. A new contract was awarded in September 2012 which included provision of CDOs and additional staff were being recruited by the contractor and trained by the PSNI during autumn 2012. It was anticipated that the recruitment of sufficient staff and a resilience pool would lead to the CDO function being signed off as a 'managed service' by April/May 2013.

Concerns were raised with Inspectors during the fieldwork period that the contractor was not always able to provide staff to cover absences, including periods of leave, which had been a particular problem over the summer of 2012. CDOs explained that they were expected to arrange their own cover when taking annual leave but that in some cases this was not possible. This was particularly raised as a problem in some of the bigger suites where shortages could leave CDOs understaffed when there was a high volume of detainees. Inspectors saw evidence of this issue where an email from a manager with the contractor advised a Custody Inspector of a number of dates where cover could not be provided. In some suites, shortages of CDOs were covered by a Constable from a response section but in others, where this was said to be an ongoing problem, local police managers had refused to provide Police Officers to fill the shortages. There is potential for difficulties to arise where suites are left short-staffed in terms of the service provided to detainees, increased workloads and the resulting stress or poor morale for staff.

It was apparent during these discussions that Custody Sergeants and Custody Managers were not aware that the CDO function was not a fully managed service and therefore saw that the contractor was failing to deliver. On further discussion with the PSNI Inspectors learnt of the contract arrangements as outlined above. It would appear there had been a misunderstanding about the contract arrangements which had the potential to impact on the staffing of the suites. Shortages had been due to annual leave, injuries and an inability to cover shortfalls by the use of overtime but this was apparently a short-term issue. Subsequently in October 2012 an email was sent by the PSNI's Outsourcing Contract Manager to clarify the situation and the stages which would be undertaken to achieve 'managed service' status. Inspectors are satisfied that this has now addressed the issues raised during the fieldwork but will return to this when this area is next inspected and will be keen to see that the 'managed service' has been implemented fully.

Recommendation 4

The requirement to print and retain paper copies of custody records from the Niche Records Management System should cease by removing all threats to the integrity of custody data, including ensuring appropriate system security controls are in place (paragraph 2.19).

Status: Partially achieved

PSNI response

Action plan:
Whilst custody records are computer based they do have to be printed and retained for several procedural and legislative reasons. Current PSNI Records Management Policy addresses the concerns re system security controls.

Latest position:
Completed as per the PSNI Action Plan.

Inspectors' assessment

Inspectors were advised that threats to the integrity of the data had been resolved with only the detainee address able to be changed. This is necessary to record relevant updates to the detainee record, for example if there is subsequent contact with police after release.

Regarding the printing of records, there appeared to be inconsistency in practice across the suites visited. In some suites staff were continuing to print full records, but two suites were not printing records at all (at the instruction of the District Commander). In most however, staff printed the first one or two pages (or retained the summary custody record printed off when the detainee first arrived) containing the detainees details and the question responses recorded on Niche when the detainee was processed (for example about healthcare needs, contact with a solicitor, informing someone of their whereabouts etc.). This was then attached to the detainees' medical record and stored in a file. As the medical records were only available as a paper form from the FMO and therefore needed to be retained, the purpose of the printed record was merely to make it easier to identify a record in the file at a later date, should it be required. For detainees who did not see the FMO there was no printing or retention of the custody record.

It is unclear why some suites continue to print custody records and yet others do not print records at all. Inspectors believe that it is unnecessary to continue printing records, save for the circumstances outlined above (where records are already printed for use when the detainee is held in the custody suite).

Recommendation 5

Reiteration of recommendations 20 and 23 from CJI/HMIC's report on Scientific Support Services in the PSNI, in terms of the PSNIs responsibilities regarding forensic evidence:
• Recommendation 20: Continued monitoring and action on quality control and continuity of evidence issues is necessary to ensure that trends and patterns within the Police Service are identified and actioned; and
• Recommendation 23: Exhibits and samples should be correctly packaged and labelled as any errors will result in delays (paragraph 3.13).

Status: Not achieved

PSNI response

Action plan:
Recommendation 20: Niche has been implemented across all districts and departments. Niche is used for all property tracking and management within districts. The Home Office Large Major Enquiry System (HOLMES) is used by C2, Serious Crime Branch within Crime Operations for property management within serious crime investigations. Two forensic trainers have been working with the PSNI College since February 2008 to ensure all training related to the recovery and management of evidential items fulfils the services needs. Scientific Support receives from the Forensic Science Northern Ireland (FSNI) customer services, all non-compliance reports for items they receive that have identified procedural or physical errors. Scientific Support collates, analyses and disseminates this information to appropriate personnel. Scientific Support send copies of each non-compliance to the relevant district or department to enable them to address the identified issue with the person responsible for causing it. Scientific Support has sent out guidance to district property managers enabling them to act as quality control managers for items they receive and are asked to store or transport. Enterprise Solutions are in the process of developing an internal non-compliance form (PS4) within Niche for use by the property managers.

Recommendation 23: As above.

Latest position:
Recommendations 20 and 23 - As a direct measure of the quality of forensic evidence recovery (including packaging, labelling, integrity of packaging and continuity of evidence handling) the PSNI has in the previous three years fully implemented the use of Niche (IT software) property management system and for serious crime, the use of HOLMES property management system. Both these systems provide detailed recording of property movements and storage. The PSNI Scientific Support Branch continues to receive from FSNI and PSNI Fingerprint bureau, copies of each non-compliance issued. In 2009, the number of non-compliances issued was 320, action was taken to try and reduce this number. In 2010, 209 non-compliances were issued. In 2011, 372 non-compliances were issued. It should be noted that not all non-compliances issued relate to packaging, labelling, integrity and continuity. From April 2012 to present, a project is being progressed with the PSNI Training College (with the PSNI's forensic trainer) to identify, with as much detail as possible, the source of these non-compliances and put in place corrective actions. The target for the end of 2012 is to achieve the 2009 level or below.

Inspectors' assessment

Fridges and freezers for the storage of samples (for example, for testing blood alcohol levels or deoxyribonucleic acid (DNA) were located in all but one custody suite visited. Custody staff were not, however, responsible for these and did not play any role in their management. Since the 2009 inspection property managers had been appointed in each district and were responsible for the management of exhibits and samples, including those located in the custody suite. Inspectors were advised in most suites that a courier removed the samples from the fridge and freezer on a specific day or days each week. During the fieldwork the fridges and freezers were inspected to ascertain the age of samples contained therein, whether any items were present which should not be, and the overall quality of the appliances.

In most suites there appeared to be a section of the freezer which was for 'current' samples, which were dated in the last few days or weeks before the inspection. In addition, in many of the freezers there was then a separate section or sections (usually separate drawers) containing older samples, most of which had been taken more than three months previously. Five of the 10 suites contained samples that were dated three to six months previously, six of the 10 contained samples that were dated six to 12 months previously, and five of the 10 contained samples that were dated over 12 months previously; the oldest ones seen being dated 2006 and 2008. The number of these varied from four or five individual samples to two or three drawers full of samples. In addition, in at least three of the 10 suites, samples were seen which were not appropriately packaged (for example, vials were undated, not labelled or bagged appropriately). In two suites, food was stored alongside samples in the freezer.

A submission record was present in the suites inspected, which appeared to have been appropriately completed by Investigating Officers to enable appropriate submission of samples. In some suites there was evidence of attempts to address non-compliance issues in the form of notices on the fridge/freezer or labelling of the drawers by year of sample. There did not appear to be any regular monitoring of the temperature of the fridges and freezers (and most did not have thermometers present) which would be helpful to ensure any issues of thawing are detected as early as possible. In general the appliances appeared of an acceptable quality, although a couple would have benefited from cleaning or defrosting.

In all suites forensic kits were available for the taking of DNA and evidence in sexual assault cases, provided by the FSNI. In four of the suites there were kits present which had passed their expiry date (although in one case the out of date kits were set out on a worktop and therefore may have been awaiting disposal).

The above evidence suggests there is still work to be done by the PSNI with regard to forensic samples, particularly in respect of making decisions about samples taken more than six months ago. In situations where evidence collected is no longer required to progress a prosecution case, there is a need for samples to be appropriately disposed of. Continued retention of samples in such a way has implications for the PSNI and for the individual who provided the sample in the first place. There is also an onus on property managers to identify and

attempt to resolve non-compliance issues and on supervisors and managers to deal with continuing breaches of service procedure and policy on forensic evidence. However Investigating Officers ultimately have responsibility for evidence obtained by them in support of a prosecution file and should be held to account for failure to manage this appropriately.

Recommendation 6

The PSNI should undertake a cost-benefit analysis of the current and alternative custody healthcare models, and implement the most appropriate and cost effective model, which is managed and monitored by appropriate PSNI representative(s) (paragraph 4.6).

Status: Partially achieved

PSNI response

Action plan:
The provision of custody healthcare is currently the subject of a review by the Northern Ireland Office.

Latest position:
A cost-benefit analysis has been completed and approved by the Local Crime and Governance Board and the Healthcare Governance Board. Phase 1 has been developed on this basis and new contracts are ready to be implemented.

Inspectors' assessment

This recommendation was also supported by a Northern Ireland Office report, *'Review of Healthcare Provision in Custody Suites within the Police Service of Northern Ireland'* which was published in June 2009. The report sets out 15 recommendations many of which were in the process of being implemented by the PSNI.

Inspectors were informed that Phase 1 of the cost benefit analysis had been implemented, the FMO service has been reviewed and new individual contracts were issued on 1 June 2012 to 50 FMOs. The Head of Custody Healthcare provided information on Phase 2, which was a business case for the provision of healthcare in custody suites. However this could not progress until a change was completed to the PACE Order 1989 Code C.[5] A Department of Justice (DoJ) consultation had been undertaken on changes to PACE which concluded in March 2012. Representatives from the PSNI were due to appear before the Committee for Justice regarding these PACE changes after the inspection in order to instigate further meetings with the Department of Health, Social Services and Public Safety regarding their role and support in the future relating to custody healthcare.

Since the last inspection, the GMC introduced arrangements through which every doctor wishing to remain in active practice in the United Kingdom is required to hold a licence to practice. All doctors are required to undergo a process of revalidation if they wish to retain their licence to practice. The process of revalidation involves each doctor collecting a portfolio of evidence over a five year cycle. This will be reviewed at an annual appraisal, against standards set out by the GMC and relevant Royal Colleges.

On 23 June 2010, the Northern Ireland Assembly enacted legislation entitled *'The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010.'* The regulations came into operation on 1 October 2010 and require each designated body, including HSC Trusts, to nominate or appoint a Responsible Officer. Every doctor is required to have a named Responsible Officer. The Responsible Officer is a statutory position. Responsible Officers will make revalidation recommendations to the GMC concerning doctors linked to their organisation.[6] Discussions with the Head of Custody Healthcare

5 PACE Code C refers to the provision of medical service by *'a forensic medical officer'*. It was proposed to change this to *'an appropriate healthcare professional'* which would enable medical services to be provided by for example forensic nurses, paramedics or forensic medical officers as appropriate.

6 The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 Duty to nominate or appoint Responsible Officers
3.—(1) Subject to the following provisions of this regulation, every designated body must nominate or appoint a Responsible Officer.
(2) When a Responsible Officer nominated or appointed in accordance with paragraph (1) ceases to hold that position, the designated body must nominate or appoint a replacement as soon as reasonably practicable.
(3) A body listed in Part 2 of the Schedule which is a designated body by virtue of regulation 2(3) is not required to nominate or appoint a responsible officer if, and for so long as, there is no prescribed connection under regulation 8 between that body and any medical practitioner.

and Lead FMO for the Belfast area indicated that this is an outstanding area which requires action. This issue has also been raised with the Department of Health, Social Services and Public Safety which is in the process of reviewing this issue.

The problems with governance arrangements for the FMO service remains that this is not a managed service, however the PSNI had begun to check GMC Registration and FMOs had been checked through PSNI vetting. There existed an Association of FMOs in Northern Ireland (AFMONI) which has an executive team of four Senior FMOs. The AFMONI performed the role of a representative group for the FMOs in order to consult with the PSNI on issues affecting their members. They had also obtained collective insurance for members rather than each taking individual indemnity insurance. The AFMONI however had no official governance arrangements, with members working independently, and policy and procedure information being forwarded to members on an advice basis. The PSNI had introduced a monitoring system to obtain data about the service including the recording of response times, complaints etc.

At the time of the previous inspection, Inspectors were not informed that there may be retired General Practitioners working for the PSNI. These doctors should be checked to ascertain if they are on the Northern Ireland Primary Care Performers List. They are required to be on this list if they provide primary care services. If they are on that list, they then are required to undergo an annual appraisal and they should also have a Responsible Officer at the HSC Board. However this may not be the case if their only work is as a FMO and they are not employed by any HSC organisation. In this case they will still be required to undergo an annual appraisal and have a Responsible Officer if they are to retain a GMC Licence to Practice.

The lead FMO for the Belfast area, who was also Honorary Secretary of the AFMONI, advised Inspectors that regular meetings were now taking place between himself and the PSNI. Training continued to be given to the FMOs by the lead FMO for Belfast, who had been responsible for setting up both the AFMONI and an FMO course at the University of Ulster. Inspectors had the opportunity to speak with a FMO who had only been in post for approximately three months, who stated that they had received three training evenings, they then shadowed an experienced FMO and were shadowed to ensure that they were competent. This FMO also stated that the Administrative FMO was available by phone if required.

Inspectors also identified issues about patient confidentiality during the inspection, with medical information being accessible potentially to non-medical staff. In one medical room detainee prescribing records, medical staff witness statements and detainee medical notes were easily accessible in unlocked filing cabinets and on the medical room desk.

Whilst no evidence was provided to suggest that FMOs were placing the health of detainees in jeopardy, the fact that this continues to be a unmanaged service is still of concern.

Recommendation 7

Resuscitation equipment should be regularly checked in accordance with guidelines and staff should be appropriately trained to use it (paragraph 4.7).

Status: Achieved

PSNI response

Action plan:
Custody staff attend first aid training in which the use of, and requirement to check oxygen therapy units on a monthly basis is addressed. To assist in the monthly check a 'Monthly Maintenance Record for Oxygen Cylinders and Regulators' is available to custody staff. The record when completed remains with the Oxygen Therapy Unit for inspection by Custody Managers and the Northern Ireland Policing Board Independent Custody Visitors.

Latest position:
Completed as per action plan.

Inspectors' assessment

Inspectors found that resuscitation equipment available in custody suites was checked and signed by custody staff on a monthly basis. Equipment was accessible in all but one custody suite where items stored in front of the equipment would hamper access in an emergency situation. This was immediately brought to the attention of the CDOs on duty at the time of the visit. Oxygen was stored in an upright position and custody staff spoken with all stated that they received yearly training in the use of oxygen, the defibrillator, and first aid every three years. During the previous inspection, a policy was available which stated that Custody Officers should be provided with refresher training for defibrillator equipment every six months. In 2010 guidelines were issued by the Resuscitation Council (United Kingdom) which includes a chapter on the use of automated external defibrillators. It is advised that policies are reviewed to ensure that they reflect any changes required by the new guidelines.

Recommendation 8

An overarching protocol for healthcare provision should be developed, in the interests of public safety, with Department of Health, Social Services and the Public Safety to enable PSNI Officers to be able to work more effectively in partnership with local emergency and mental healthcare services (paragraph 4.9).

Status: Partially achieved

PSNI response

Action plan:
The provision of custody healthcare is currently the subject of a review by the Northern Ireland Office. Operational Procedure and Guidance for dealing with persons with a mental disorder is currently available and this includes direction on working in partnership with other relevant statutory agencies.

Latest position:
The *PSNI have worked with the Guidance and Audit Implementation Group to develop roles and responsibilities for the Health Service, the Northern Ireland Ambulance Service and the PSNI, ensuring there is clarity on whose responsibility it shall be in relation to the Mental Health Order. This guidance is now on PoliceNet.*

Inspectors' assessment

CJI's March 2012 report *'Not a marginal issue: mental health and the criminal justice system in Northern Ireland: a follow-up review of inspection recommendations'* also reviewed progress against recommendations which covered this area. Recommendation 2 in the original report was for *'the PSNI to finalise a protocol with the Health Service making clear the precise respective responsibilities of the two services so that there is clarity about how individuals with a mental health need are to be handled'*. The Inspectors' assessment in the follow-up review is included at Appendix 1 of this report, but this recommendation was assessed as not achieved.

Since this follow-up review and the original inspection in 2009, work had been ongoing to provide an overarching protocol for healthcare provision,

however this can not be fully achieved without changes to the legislation. Inspectors were provided with a draft *'Regional Interagency Protocol: The Mental Health (Northern Ireland) Order 1986'*. The purpose of this document was to provide a framework for co-operation and joint working between the PSNI, the Northern Ireland Ambulance Service, and the HSC Trusts to ensure that people with a mental illness are managed in a safe, effective and appropriate manner. When this is completed it should provide greater clarity in this area. In addition, a DoJ consultation was also underway at the time of writing, on proposals to extend mental capacity legislation to the criminal justice system in Northern Ireland and implications for mental health powers. This consultation was closed in October 2012.

Additional information

Similarly the CJI follow-up review on mental health and the criminal justice system commented on the use of mental health staff in PSNI custody suites. The report recommended that '*The Mentally Disordered Offender Scheme should be extended to all custody suites in Northern Ireland.*' The Inspectors' assessment in the follow-up review (see Appendix A) also assessed this recommendation as not achieved. In this follow-up review of police custody Inspectors assessed the provision of services for detainees with mental health needs and drug addictions.

Two Community Psychiatric Nurses based in Musgrave Street continued to provide a service for detainees with mental health needs, however no cover was provided for annual leave etc. and they were also expected to work in emergency departments within the Trust unscheduled care team as part of their role. This service had not extended since the last custody inspection, and in fact the Community Psychiatric Nurses had received a new directive from Belfast HSC Trust that they were no longer able to screen all detainees in custody for mental health needs (based on issues around confidentiality and data protection). The Community Psychiatric Nurses therefore only saw detainees on the request of the FMO and were no longer able to take direct referrals from a Custody Sergeant or CDOs. The Community Psychiatric Nurses spoken with were concerned that a detainee they previously could have screened for mental health needs may not be seen by the FMO or may not be referred for mental health treatment. They commented that the Drug Arrest Referral Team has been allowed to continue to screen all detainees in custody, based on strict criteria.

A review of the service had recently been undertaken but the Community Psychiatric Nurses were not aware of the outcome. The Nurses had no access to the Trust intranet system and patient records for example medication, previous medical history etc. which would assist them in their role. It was especially difficult to get healthcare information on detainees at the weekend. This inability to access computer records could result in an overlap with the work which is already being provided for detainees in the community by the Home Treatment Team and which may be repeated. The Community Psychiatric Nurses would welcome a system where one Trust has sole responsibility for the delivery of mental health care to custody detainees and additional support from their line managers in relation to the delivery of the service.

Initially these Nurses had been involved in custody training but not within the last two years. The Nurses stated that they had a good working relationship with custody staff who welcome their input, and this was also highlighted during focus groups with custody staff. They felt that detainees with mental health needs were well cared for by custody staff and that they were tolerant of the detainees' challenging behaviour.

There were still three Drug Arrest Referral Teams in Belfast, Derry/Londonderry and Ballymena. These remain as a DoJ Community Safety non-recurring funded project. Discussion with two of the teams would indicate that there are variations in the provision of service and the type of detainees reviewed. For example, in Ballymena referrals were received from visits twice a day to the police custody suite, and the Reducing Offending Unit. The team reviewed all detainees in custody, no matter what the situation was unless they were advised by custody staff that it was not safe/appropriate. The team were also a point of contact for those released from prison, and could contact prison healthcare prior to a detainee being admitted to provide the necessary

information. The team would like to expand their work to do 'in-reach' in prisons, however this was not possible with current staffing levels.

The Drug Arrest Referral Team in Musgrave Street was comprised of a Nurse, Social Worker and a Counsellor, based between Malone Place and Musgrave Street Police Station. They only saw detainees with drug problems and did not see detainees who were arrested on suspicion of committing crimes from grievous bodily harm with intent, upwards. They had developed a new link with the Catch and Control Team (part of the Reducing Offending Unit) which was due to commence the following week. This would enable them to see those detainees with additions on bail restrictions. Both teams could still screen detainees.

Inspectors found that both the Drug and Community Psychiatric Nurse teams in Musgrave Street offered a much needed service, however both were under review at the time of the follow-up review, which had affected morale. The provision of a regional service for mental health and addictions would assist in reducing variations in practice and greatly enhance the overall care of detainees. In addition, the adoption of a similar model to that used in Ballymena with more in-reach into the prison and emphasis on Reducing Offending Unit, may assist in the number of re-offences.

Recommendation 9

The cleaning and infection control procedures in medical rooms should be reviewed in light of the SDHP guidelines, with appropriate input from custody experts, and the practice of using a medical room for anything other than forensic medical purposes should desist immediately (paragraph 4.11).

Status: Partially achieved

PSNI response

Action plan:
A review of the procedures has concluded that the procedures for cleaning and use of the medical room meet the requirements as set out in the SDHP. A reminder of current procedures for both the cleaning and use of medical rooms has been circulated to all relevant staff.

Latest position:
Completed as per PSNI Action Plan.

Inspectors' assessment

The majority of medical rooms inspected were clean and uncluttered, equipped to the required standard and afforded an appropriate level of privacy and decency. On only one occasion was there a need for additional cleaning, some equipment such as blood pressure cuffs were old, one was soiled and most were not of a material that could be cleaned. In addition, some sterile equipment was out-of-date. Inspectors noted many recurring issues, such as the lack of a hand rub to decontaminate hands, except in the medical room of Musgrave Street custody suite. In all instances the bags used for the disposal of clinical waste were orange, which is the colour used in England but not Northern Ireland. In most cases sharps containers were wall mounted in a locked outer casing. The key for these was unavailable, therefore Inspectors were unable to check if boxes were labelled, dated and signed - however this was again noted for boxes that were not in this sealed container. The correct labelling ensures that the area the sharps box originated from can be immediately identified. In two medical rooms, domestic fridges were used for storing medication such as insulin. These were unlocked and temperatures not checked. It is important that fridge temperature checks are taken and recorded on a daily basis to ensure medication is stored at the correct temperature and to identify any failures in the cold chain.

Custody staff spoken with stated they had not received infection prevention and control training and they were uncertain about infection control and the risks associated with it including, for example, the risks associated with exposure to blood and body fluids. Custody staff also highlighted that at times there are difficulties in accessing out-of-hours cleaning services, therefore cells had to be closed. Cleaning staff spoken with were trained to The British Institute of Cleaning Science Level 1 and some had commenced Level 2 training. In most instances the colour coding of cleaning equipment was in place,

however Inspectors noted that there were times when the colours of equipment was mixed. Colour coding of cleaning materials and equipment ensures that these items are not used in multiple areas, therefore reducing the risk of cross-infection. The cleaning contractor had introduced a new disinfectant, however staff spoken with were unaware of the correct dilution rate and also the correct equipment for the dilution of the disinfectant had not been supplied. In one instance the medical room was still being used inappropriately, as a kitchen for the custody suite and a storage area. Plans were in place to partition off the area used for the medical room but it was difficult to see how this would provide sufficient space to conduct a medical examination and discussion with the detainee appropriately.

Recommendation 10

The PSNI should urgently review its policies and procedures for the safe selection, procurement, prescription, supply, dispensing, storage, administration and disposal of medications. There should be a clear audit trail in place for the management of medications (paragraph 4.16).

Status: Not achieved

PSNI response

Action plan:
A review of current procedures has now commenced and will include consultation with the Senior Forensic Medical Officer. Any required amendments will be made and the Service Procedure re-issued.

Latest position:
The *PSNI Custody Policy Directive 5/09 has now been updated and published to include the updated list of medication for storage in custody suite medical cabinets. The Directive also contains instructions that the medical cabinet key be kept on the person of the Custody Sergeant and not retained by the FMO or left hanging in a key cabinet. PSNI procedures for the procurement, storage, disposal etc. of medication are deemed fit for purpose by the Senior FMO [for Belfast].*

Inspectors' assessment

The policy on the stocking of drugs cabinets in medical rooms of PSNI stations had been updated. Inspectors found that drugs cabinets were available in medical rooms of PACE designated stations, which at the time of inspection were secured to the wall and locked. The policy stated that the key must be retained on the Custody Officer's person and handed over at changeover periods. Where there was no Custody Officer on duty the key should be kept by the Duty Sergeant. In all suites visited the key to the drugs cabinet was accessible in an unlocked cabinet or drawer in or beside the custody office and the controlled drugs key was either locked inside the main drugs cabinet or on the drugs cabinet keys. The policy also stated that the responsibility for the contents of the medical cabinet rests with the Custody Officer/Duty Sergeant. In one instance the drugs cabinet was identified with yellow and black hazard tape; it is recommended that drugs cabinet should not be marked to identify contents.

Inspectors found that in the majority of suites, the number and type of drugs retained did not comply with the service policy. Of concern was the continued use of Schedule 3 medication (for example, Temazepam) and other divertible medication. This is particularly concerning as the prevention of unauthorised access to medication could not be assured and Inspectors found that there was still no clear audit trail available for the management of medications. The policy stated that Custody Managers must carry out an audit of medication on a monthly basis which should confirm that any medication held, issued or destroyed reflects the records as contained in the notebook and corresponding PACE 15/1. Any discrepancies should be reported for further investigation. Details of the audit should be recorded in the notebook contained in the medical cabinet. In some stations there had been some attempt to record medications received, retained and signed by a FMO and Custody Sergeant. However there was still no record of the number of medications administrated or disposed of, and non-compliance with policy was evident. Since the previous inspection, *'Controlled Drugs (Supervision of Management and Use) Regulations 2009'* and *'Safer Management of Controlled Drugs July 2011: A guide to good practice in primary care (Northern Ireland)'*

legislation has been introduced and, a review of whether these are applicable needs to be undertaken.

There remain concerns regarding the administration of medication and the storage of unused drugs. Detainee medication once dispensed was stored out of its original packaging in clear plastic bags. In many occasions this bag had no detainee name, the name of the medication nor the dose etc. and was clipped to a file in the custody reception. The storage of unused medication varied from being locked in a drugs cabinet or in a drawer in the medical room to being stored in a file box at the reception desk. The Lead FMO for Belfast stated that he was devising a new policy which would address these issues and Inspectors requested that this be forwarded on completion. This area requires immediate attention and it is concerning that since the last inspection over three years ago the safe use and control of medicines cannot be assured.

Recommendation 11

The PSNI should, in conjunction with the United Kingdom Border Agency (UKBA), explore alternatives to the use of traditional police cells for holding immigration detainees who are detained for more than 36 hours (paragraph 5.3).

Status: Achieved

PSNI response

Action plan:
The detention of immigration detainees is being considered as part of an external review of police custody. Consultation is currently ongoing between the PSNI and the UKBA to progress this issue.

Latest position:
Since this recommendation the alternative use of traditional police cells for holding immigration detainees who are detained for more than 36 hours has been progressed, as UKBA personnel have corresponded with the PSNI and an agreement has been reached regarding charging the UKBA for detainees.

Inspectors' assessment

In July 2011 the UKBA opened Larne House Short-Term Holding Facility to accommodate up to 19 detainees. Larne House was developed as a result of discussions between the PSNI and UKBA which led to the leasing of Larne police custody suite to UKBA for conversion into a facility suitable for holding immigration detainees. The majority of detainees located in Larne House arrived from Drumkeen House, the UKBA reporting centre in Belfast, or from one of Belfast's two airports. Prior to the opening of Larne House most of these detainees would have been held in police custody. Larne House was subject to its first inspection by HMIP (who have the statutory remit to inspect UKBA detention facilities across the estate) in November 2011.[7]

Custody Sergeants advised that they rarely received immigration detainees in police custody with most being taken straight to Larne House. They also confirmed that Immigration Officers were prompt in serving immigration papers and having detainees removed from police custody. Figures provided by the PSNI indicate that in 2011-12 179 immigration detainees were held in PSNI custody suites. This figure accounts for 0.7% of those held in police custody. This is a reduction from the proportion of immigration detainees held in the two years preceding the 2009 inspection of around 2%. These figures include both the period before and after Larne House was opened.

Of the 179 detainees held in 2011-12 overall 125 were held for less than 36 hours, two for 36 hours and 52 for more than 36 hours. However when the figures are compared for the period between 1 April and 11 July 2011 (when Larne House opened) and from 11 July 2011 to 31 March 2012 it is evident that the new facility has led to a significant reduction in immigration detainees held in police custody. The following table shows the detention times for detainees during these two periods.

7 The inspection report is available at http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/short-term-holding-facility-reports/larne-house-2011.pdf.

Table 1: Detention times for immigration detainees held in police custody

	1 April 2011 - 10 July 2011	11 July 2011 - 31 March 2012
Detention less than 36 hours	40 (47.1%)	85 (90.4%)
Detention equal to 36 hours	0	2 (2.1%)
Detention more than 36 hours	45 (52.9%)	7 (7.4%)
Total	**85**	**94**

It is clear that the opening of Larne House has had a positive impact on the holding of detainees in police custody. Inspectors were advised that the PSNI had gone to great lengths to facilitate and support the opening of a short-term holding facility by the UKBA. The UKBA were positive about the treatment and conditions for detainees in police custody. There is likely to continue to be a need for a small number of immigration detainees to be held in police custody, for example when they have been arrested for criminal matters as well as immigration issues or where they are arrested for violent behaviour and therefore unsuitable to be transferred to an immigration facility. The reduction in numbers in police custody is a positive outcome for the agencies and for the detainees themselves who will be detained in more suitable conditions.

Recommendation 12

Hygiene packs for female detainees which include hygienic and discreet supplies of sanitary items should be obtained and available in the custody suites (paragraph 5.7).

Status: Achieved

PSNI response

Action plan:
Female hygiene packs have been approved by the PSNI Custody Working Group. An information pack outlining availability has been circulated to all custody staff.

Latest position:
Completed as per PSNI Action Plan.

Inspectors' assessment

Female hygiene packs which contained individually wrapped sanitary items were available in every custody suite. The packaging for the packs was a clear plastic bag which meant they were not as discreet as they could be, but this meant that it was easy to check the contents were present and had not been tampered with.

Additional information

One of the expectations[8] relating to detainee care states that *'detainees are able to be clean and comfortable while in custody'* and an indicator for this is that *'hygiene packs for women are available, and are routinely offered on arrival and on request'*. Most Custody Officers suggested to Inspectors that detainees would have to request a hygiene pack rather than them being offered routinely. In the larger suites there was usually always a female Detention Officer on duty but in locations where there was only one or two Detention Officers working alongside the Custody Sergeant this was often not the case. Inspectors were advised that where no female Detention Officer was available but a female detainee was brought into custody a female Officer would be requested, and usually provided, from one of the station response sections. They would be present for the booking in and searching of the detainee but would not usually stay for the full duration of their detention, unless it was a female child. It would be sensible if packs were offered routinely by a female Detention Officer on arrival in the custody suite.

8 A framework of expectations was developed in England and Wales by HMIP and HMIC, which was adapted for use in Northern Ireland.

CHAPTER 3:

Conclusion

Since the previous inspection the PSNI had undertaken their own review of police custody provision and had plans in place to develop the service. Progress had been made in relation to the recommendations regarding the provision of a custody 'hub' on the intranet, the use of custody staff who were appropriately trained in the role, the checking of, and training in, the use of resuscitation equipment, the opening of the Short-Term Holding Facility by the UKBA for immigration detainees, and the availability of hygiene packs for female detainees. In addition some noticeable improvements had been implemented over and above the recommendations (for example, the opening of the new custody suite in Musgrave Street to serve B District and the introduction of CDOs across the estate).

At the time of this follow-up review however, there had been limited progress towards some of the more challenging, overarching recommendations made in the 2009 inspection. The PSNI had not made final decisions about moving to a centralised model which continued to result in inconsistency of delivery across the estate. There were still issues with the overall management of custody provision, as a result of the devolved custody management structure.

Staff within custody suites remained committed to the role and were clearly focussed on providing an effective service and discharging their responsibilities in relation to the treatment and conditions of detainees. Issues with the storage and disposal of forensic samples were still apparent in most suites visited.

Some progress had been made in order to address the issues in relation to healthcare identified in the first inspection, but Inspectors still had a number of concerns about the service. The PSNI were seeking changes to legislation surrounding the provision of healthcare services in custody suites and this is essential before consideration can be given to alternative models of healthcare delivery. In the interim they had introduced a new contract for the FMOs which aimed to ensure a more standardised approach to payments and terms and conditions in an effort to reduce costs.

Difficulties still existed with the service provided to detainees with mental health needs or the potential to require support from mental health professionals. The PSNI were working with partners in the Department of Health, Social Services and Public Safety to progress this and Inspectors would encourage the PSNI to continue to engage fully in order to identify appropriate solutions. Some improvements had been made in the approach to the cleaning and infection control procedures in the medical rooms and most were clean and uncluttered, however there was still evidence of the need for improvement. In one suite the medical room continued to be inappropriately located within the room also used for the kitchen.

There was still evidence of poor practice in most locations in relation to the approach to medications and limited evidence of an audit trail. Attempts had been made in some areas to ensure adherence to procedures and implement more effective systems for the tracking of medications. However there were still inconsistencies in practice across the estate and therefore the safe use and control of medicines cannot be assured.

It is important now that the PSNI quickly makes decisions about the future structure for the provision of the custody service, and begins to implement the necessary management arrangements to provide

governance for this. The inconsistencies in practice and service delivery highlighted throughout this report will be much easier and quicker to address through consistent management and governance. The PSNI also needs to continue to work with all relevant partners in order to ensure delivery of an effective custody service which meets the needs of detainees in their care.

Section 2

Appendix

Appendix 1: Extract from CJI report *'Not a marginal issue: mental health and the criminal justice system in Northern Ireland: a follow-up review of inspection recommendations'*

Recommendation 2

2.14 *The PSNI should finalise a protocol with the Health Service making clear the precise respective responsibilities of the two services, so that there is clarity about how mentally disordered persons are to be handled.*

PSNI response

2.15 *A working group consisting of representatives of the PSNI and the Health and Social Services Care Board are engaged in a series of meetings regarding protocols on places of safety, AWOL [absent without leave] patients and mental health assessments on private premises. In the course of this work, opportunities for further collaboration have been identified, notably a protocol in relation to people ingesting substances.*

2.16 *The aim of this GAIN-funded audit is to produce draft guidelines and a framework for dealing with future legislation changes by September 2011.*

2.17 *Steps are in place to achieve the recommendation by September 2011.*

Inspectors' assessment

2.18 Inspectors were advised that the PSNI were working with the Health and Social Care Board (HSCB) to consider a range of issues, one of which was the protocol referred to in this recommendation. Much of the emphasis has been on obtaining the views of Operational Officers, for example Custody Officers, and Forensic Medical Officers (FMOs). As a result of this work opportunities for further joint work have been identified. Also considered relevant is the application of the corporate manslaughter provisions to custody suites, given the PSNI's potential liability during the 48 hours immediately post release from custody.

2.19 During the fieldwork Inspectors were advised that the PSNI aimed to have this work completed, i.e. the production of draft guidelines and a framework for dealing with future legislation, by September 2011. While care pathways are being developed, a wide range of data collection is required to inform the process. As a result, Inspectors were advised that the timescale for the completion of the protocol had been put back, that the protocols could not be developed until the guidance was complete, and that the guidance would be available from October 2011. The projected date for completion of the protocol is now the end of the 2011-12 financial year.

2.20 The inspection report highlighted the need to build a better understanding between the PSNI and the Health Service around issues involving mentally disordered persons. The report acknowledged that some tension between the two services was unavoidable because of the competing pressures faced by both. In the current economic climate these pressures will inevitably increase, and Inspectors would again urge the PSNI, in conjunction with its partners in the Health Service, to finalise and publish the protocol for the benefit of those mentally disordered people who come into contact with the criminal justice system, and for the front-line service-deliverers in both organisations.

2.21 Subsequent to the fieldwork, Inspectors have been advised by the PSNI that the guidance has been developed and is published clearly outlining the roles. However, the protocols for each specific Trust have not been developed following publication of the guidance. The PSNI stress this is outside of its control as the HSCB is taking this forward, as only it can designate 'places of safety' according to the legislation, and that the PSNI has taken this

recommendation as far as it can. Whilst Inspectors acknowledge that work has taken place, and is continuing, in respect of the protocol, and that the protocol cannot be finalised by the PSNI alone, the protocol has not been finalised and therefore the recommendation cannot be assessed as having been achieved.

Status: Not achieved.

Recommendation 4

2.34 *The Mentally Disordered Offender (MDO) scheme should be extended to all custody suites in Northern Ireland.*

PSNI response

2.35 *This recommendation has been overtaken by the integration of the MDO scheme within an unscheduled care service, which conducts risk assessments at Belfast Trust Accident and Emergency Departments (A&Es)/Musgrave Street on request.*

2.36 *The working group mentioned at Recommendation 2 is evaluating the unscheduled care service and will take into account the outcome of an ongoing review of custody provision in considering the potential to strengthen/roll out the service beyond Belfast.*

Inspectors' assessment

2.37 In the initial inspection report, CJI Inspectors highlighted their highly positive assessment of the MDO Scheme and expressed surprise when they discovered that there was some uncertainty about the future of the Scheme, and that it would possibly be absorbed into community psychiatric nursing.

2.38 Inspectors spoke to Custody Sergeants as part of the fieldwork for this follow-up review and, again, received very positive feedback about the role of the CPNs. The only negative comments were in relation to their potential unavailability at night and at weekends, when Custody Officers often had to deal with difficult cases.

2.39 The CPNs had a good knowledge of many of the people with mental health issues who were regular attendees at the Belfast custody suites. They had access to the Trust IT systems, General Practitioners (GPs) in the community and could access healthcare information relevant to the person concerned.[9] In addition, CPNs had links with Hydebank Wood and Maghaberry prisons and could make recommendations to the prison healthcare staff if the detainee was to be remanded in custody. Inspectors viewed this as a good example of an effective information sharing service which is joined-up across different departments and criminal justice agencies.

2.40 The MDO Scheme[10] referred to in the original inspection report had been integrated within an unscheduled care service which covers the Belfast Trust's A&E Departments and the Belfast PSNI custody suites on request.

2.41 This recommendation was discussed at the CJB [Criminal Justice Board] Mental Health Sub-Group where the HSCB advised that as well as being unaffordable, the recommendation has been overtaken by the integration of the former MDO Scheme within an unscheduled care service. The HSCB also advised that having nurses on-site every day had been an inefficient use of resources as the work demands were greater after normal working hours. The Sub-Group was advised that the HSCB wanted to examine how well the revised approach was working relative to the previous one and to consider how best the new model could be rolled-out to other areas, and, as not all Trusts had an unscheduled care team, this may not be straightforward or cost-effective.

2.42 The PSNI was involved in the evaluation of the unscheduled care service which would take

9 The IT system was not accessible from the custody suite itself but from their office in the community. The CPNs made contact with GPs or other community providers from the custody suite itself via telephone.

10 The MDO Scheme is not a PSNI function. The Scheme is funded and staffed by the Belfast Health and Social Care Trust.

into account the outcome of the ongoing review of custody provision in considering the potential to strengthen/roll-out the service beyond Belfast.

2.43 The unscheduled care service that is currently provided in Belfast (formerly the MDO Scheme) is the subject of evaluation before any decision about whether to continue and/or extend it beyond Belfast. Any provision of this service will be a healthcare decision and is therefore outside the statutory remit of CJI to inspect. However at the time of writing, there was no provision of this healthcare service to PSNI custody suites outside Belfast and so the recommendation can be assessed as 'not achieved'.

2.44 In light of the findings of the original inspection report, the positive feedback from Custody Sergeants, the information and medical history available to the CPNs, and the issues and risks surrounding people with mental health issues being held in custody, Inspectors fail to understand why this service continues to have an uncertain future. Whilst Inspectors are aware that the Musgrave Street model may have had its limitations, nothing has been put in place to replace it on a Northern Ireland-wide basis. The recently published Prison Review Report[11] also expressed disappointment that the scheme had not been extended beyond Belfast. The PSNI project to review the delivery of custody is not scheduled to report until early 2013, three years from the date of the original CJI recommendation and, although it is not clear what the timescale is for the HSCB evaluation of its unscheduled care service, it would appear that there is unlikely to be further progress in respect of this recommendation until at least March 2013.

2.45 As a result of this, and the cross departmental nature of the issue, Inspectors would urge the Justice Minister to review developments within the DoJ and raise the matter with his counterpart in the DHSSPS.

Status: Not achieved.

11 *'Review of the Northern Ireland Prison Service: Conditions, management and oversight of all prisons'.* Prison Review Team, Final Report October 2011.

First published in Northern Ireland in February 2013 by
CRIMINAL JUSTICE INSPECTION NORTHERN IRELAND
14 Great Victoria Street
Belfast BT2 7BA
www.cjini.org

Typeset in Gill Sans
Designed by Page Setup