Criminal Justice Inspection Northern Ireland
a better justice system for all

POLICE CUSTODY

THE DETENTION OF PERSONS IN POLICE CUSTODY IN NORTHERN IRELAND

A FOLLOW-UP REVIEW OF INSPECTION RECOMMENDATIONS

JULY 2025

The **Regulation** and **Quality Improvement** Authority

CONTENTS

Note: Electronic links to documents and information sources referenced within this report are correct at the time of publication but may be subject to change where the information is outside CJI's control.

LIST OF ABBREVIATIONS

APP	Authorised Professional Practice
CCTV	Closed Circuit Television
CDO	Civilian Detention Officer (within PSNI)
CJI	Criminal Justice Inspection Northern Ireland
CNP(s)	Custody Nurse Practitioner(s)
CPR	Child Protection Register
DoH	Department of Health
DoJ	Department of Justice
ED	Emergency Department
FFLM	Faculty of Forensic and Legal Medicine
FMO	Forensic Medical Officer
HCP	Health Care Professional
HSCT(s)	Health and Social Care Trust(s)
ICVs	Independent Custody Visitors
JJC	Woodlands Juvenile Justice Centre
LPT	Local Policing Team (within PSNI)
Niche™ Records Management System	Records Management System developed by Niche™ Technology Inc (used by the PSNI)
NICCY	Northern Ireland Commissioner for Children and Young People
NIECR	Northern Ireland Electronic Care Record
NIPB	Northern Ireland Policing Board

NIPS	Northern Ireland Prison Service
NPCC	National Police Chiefs' Council
NPM	National Preventive Mechanism
OPONI	Office of the Police Ombudsman for Northern Ireland
PACE	Police and Criminal Evidence (Northern Ireland) Order 1989
PECCS	Prisoner Escort Court Custody Service
PHA	Public Health Agency
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
UNCRC	United Nations Convention on the Rights of the Child
UK	United Kingdom
YJA	Youth Justice Agency

CHIEF INSPECTOR AND CHIEF EXECUTIVE'S FOREWORD

Police custody is often an adult or child's first experience of detention and it can be a daunting experience, including for those who have mental health and addiction issues, those who are neurodiverse and those who need access to physical and mental health care. It can also be a challenge for Custody Suite detention and health professionals who are providing services for them.

There has been some time since the full Inspection Report was published. While recognising what has been done to implement or partially implement 11 of the nineteen Recommendations and Areas for Improvement, and the challenges and opportunities presented by the COVID-19 pandemic, there is still work to do on some critical issues.

The ambition for, and proven benefits of, a nurse-led service model has not progressed sufficiently. This needs to be resolved as soon as possible. The Police Service of Northern Ireland should have a consistent quality health service model for its custody suites across Northern Ireland that is not geographically dependent. We expect that by the time of the next full Inspection this is in place and operating well.

The Police Service of Northern Ireland has been working with health care partners on a *Right Care, Right Person* initiative and a new service model that makes better use of available police and health care resources. This also applies to police custody suites in ensuring that those in detention have access to timely and adequate physical and mental health care, but it also applies to those suspected of offences who need samples taken for evidential purposes. No one should be able to avoid detection and prosecution for driving under the influence of any substance for want of a timely sample being taken by an appropriate health care professional.

There has been impressive investment in the new Waterside Custody Suite in Londonderry/Derry and we hope that these modern facilities operate effectively at the capacity required. The long running issues around detainee transport from custody suites to prison following virtual Court appearances needs to be resolved between the Police Service of Northern Ireland and the Northern Ireland Prison Service. While the resource implications are acknowledged, the abstraction of Police Officers to transport detainees to Maghaberry and Hydebank Wood Prisons or from one side of the Foyle River to the other when the prison van is almost driving past the custody suite, is at best non-sensical in today's operating environment.

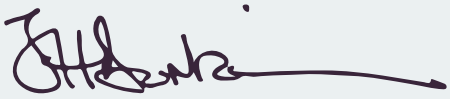
Debates about funding, resourcing and security need a solution.

There has also been some welcome progress in tabling long awaited draft legislation to address remand, bail and custody arrangements for children and young people. We look forward to seeing the final content of the new Act and its implementation to improve current provision, particularly for 'Looked After' children who are disproportionately represented and more likely to be detained in custody because they can't access social work support, go back to their children's home or find alternative accommodation. While we welcome that there are less children being detained, nearly half of them are 'Looked After' children.

We are grateful to the Police Service of Northern Ireland and Belfast Health and Social Care Trust staff, and to the detainees who engaged with our Inspectors throughout this Follow-Up Review.

As National Preventive Mechanism members we are mindful of our responsibilities to monitor and inspect places of detention and police custody as a key part of Northern Ireland's detention network.

Our thanks to Lead Inspector, Rachel Lindsay, and Inspector Maureen Erne and RQIA Assistant Director Wendy McGregor and team who carried out this Follow-Up Review and to John Wadham, Human Rights Advisor to the Northern Ireland Policing Board, and his team who also participated alongside Inspectors.



Jacqui Durkin
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July 2025

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CHAPTER 1: INTRODUCTION

BACKGROUND TO THE FOLLOW-UP REVIEW

In September 2020 Criminal Justice Inspection Northern Ireland (CJI) published a report of a full *Inspection of Police Custody*.[1] The report made five strategic and seven operational recommendations to the Police Service of Northern Ireland (PSNI). It also identified six Areas for Improvement. One of the five strategic recommendations (Strategic Recommendation 3) required the PSNI and the Health and Social Care Trusts (HSCTs) to collaborate effectively to expedite the implementation of a nurse-led custody model across Northern Ireland. Strategic Recommendation One was made to the Department of Justice (DoJ) relating to the need for legislative reform regarding children's right to bail. All recommendations were accepted.

The 2020 *Inspection of Police Custody* and this Follow-Up Review form part of CJI's monitoring of places of detention as one of four bodies in Northern Ireland that make up the United Kingdom's (UK's) National Preventive Mechanism (NPM).[2] The NPM was established in response to the UK's commitment to the Optional Protocol to the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Other members of the NPM in Northern Ireland include the Regulation and Quality Improvement Authority (RQIA) and the Northern Ireland Policing Board's (NIPB's) Independent Custody Visiting Scheme.

This Follow-Up Review was conducted jointly with the RQIA and is the fifth joint Inspection of police custody in Northern Ireland. The NIPB Human Rights Advisor and staff also took part in the Follow-Up Review and relevant observations are included within the body of this report. The NIPB is responsible for independently monitoring the PSNI's compliance with the Human Rights Act 1998, the European Convention on Human Rights and other relevant human rights instruments. Appendix 1 is an extract from the NIPB's Human Rights Monitoring Framework, that it uses to make its assessments of the PSNI's compliance with human rights standards.

1 *CJI, Police Custody, The Detention of persons in Police Custody in Northern Ireland, September 2020,* available at **Police Custody: The detention of persons in police custody in Northern Ireland - CJI NI**

2 See **https://nationalpreventivemechanism.org.uk/**.

Changes since the 2020 Inspection

Recovery from the COVID-19 pandemic

On-site fieldwork for the 2020 Inspection Report was undertaken in December 2019. The onset of the COVID-19 pandemic and associated restrictions from March 2020 had a significant impact on the delivery of police custody and associated processes, such as the introduction of video links to custody suites for first appearances at Court and a greater role for the Northern Ireland Prison Service (NIPS) Prisoner Escorting and Court Custody Service (PECCS) staff in escorting detainees remanded into custody from police custody suites to prisons.[3]

After the COVID-19 pandemic some custody suites had retained the changes implemented during the period of restrictions. For example, video links had been retained between custody suites and some Courthouses outside Belfast, not in close proximity to each other, whereas those detained in Musgrave Custody Suite in Belfast were transported to Laganside Courts by the PECCS. However, in Courts located close to the custody suite (such as Dungannon Courthouse and Dungannon Police Station) it was more likely that detainees would be transported to the Court by the PSNI. Early cut-off times for first appearances on Fridays at Londonderry Magistrates' Court were reported in Waterside Custody Suite, which led to extended periods of detention for some in custody. The PSNI were still continuing to work with colleagues across the criminal justice system on the agreed model for first appearance at Court post-pandemic. The ability of some older custody suites to facilitate Court appearances was a challenge, where the lack of dedicated rooms caused privacy and safety concerns. In more modern custody suites it was easier to adapt existing locations or provide facilities specifically for this purpose.

Photograph 1

Virtual Court Room, Waterside Custody Suite

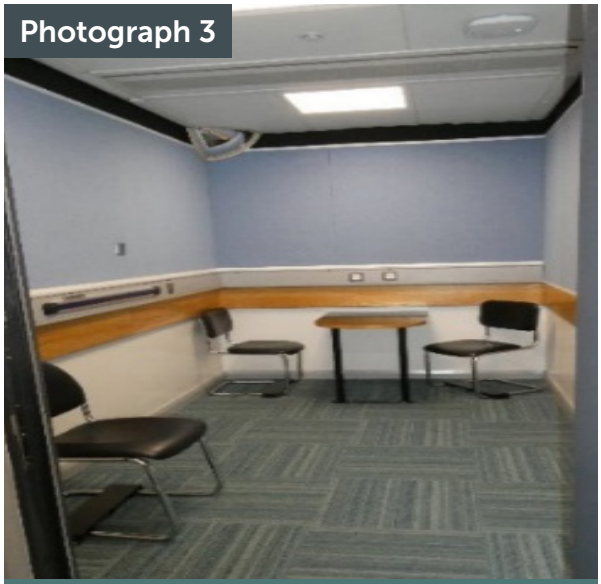
3 See *CJI, Court Custody: The Detention of Persons in the Custody of the Court in Northern Ireland, March 2022,* available at Court Custody: The detention of persons in the custody of the court in Northern Ireland - CJI NI

Photograph 2

Virtual Court Room Signage, Waterside Custody Suite

In addition, Inspectors were advised that, unlike at the time of 2020 Inspection fieldwork, solicitors frequently undertook virtual consultations and attended interviews and there was now a higher number of consultations conducted by telephone. To facilitate this, custody suites had been provided with digital tablets. As with virtual Court rooms, this was more difficult in the older, smaller custody suites that did not have appropriate facilities for consultations to take place in a confidential way while ensuring the safety of the detainee, staff and the wider public. Consultation room doors had been fitted with glass panels which could be switched to transparent from opaque, but detainees required constant monitoring while using the room and it was labour intensive. In some custody suites detainees therefore consulted with their solicitor within interview rooms that were covered by the Closed-Circuit Television (CCTV) system. There were therefore inconsistencies in the ability of detainees to consult in private with their solicitor. This, and the reduced attendance in person by legal representatives, was of concern to custody staff.

Photograph 3



Consultation Room, Musgrave Custody Suite

Photograph 4

Consultation Room door showing privacy glass, Waterside Custody Suite

The PSNI also raised concerns about resourcing challenges that were impacted by the requirement to transfer detainees to Court and to prison on remand, returning to the arrangements in place prior to the COVID-19 pandemic (as outlined earlier in this report and in CJI's 2022 Court Custody Inspection Report[4]). In all suites, except Musgrave Custody Suite, this was undertaken by Officers in Local Policing Teams (LPTs) transporting one detainee at a time in a police vehicle. The need to present a paper copy of the remand warrant at the prison was also reported as causing delays. In addition, PSNI LPT Officers were required to transport detainees remanded after their first appearance from Waterside Custody Suite to Londonderry Courthouse into the care of the PECCS for onward transportation to Maghaberry Prison. Inspectors were advised that this could require several police cars to transport detainees, depending on the number in custody at that time, rather than all being collected by the PECCS in one multi-celled prison van. This diverts resources from the PSNI's front-line response and availability to attend critical incidents and calls for service.

In the 2022 Inspection Report on Court Custody CJI recommended that '*The Prisoner Escorting and Court Custody Service and the Police Service of Northern Ireland should take action to improve the arrangements for the delivery of escorting services between police custody, courts and prisons:*

- *the current Service Level Agreement should be reviewed and enhanced within three months of the publication of this report to include performance indicators for service delivery; and*
- *a target operating model should be designed and scoped, within nine months of the publication of this report, whereby the Prisoner Escorting and Court Custody Service undertakes all escorting to court and to prison apart from in exceptional circumstances.*

At Factual Accuracy Check stage, the NIPS advised that the NIPS/PECCS did not have resources to maintain pandemic arrangements in a business-as-usual situation where Courts returned to in person hearings and prisoners were being escorted to and from Court and managed in Court custody suites. Further, that the accepted recommendation from the Court Custody Inspection Report was neither affordable nor deliverable for NIPS/PECCS. Also, they noted that NIPS/PECCS had engaged in a joint DoJ working group and had, with partners, submitted a draft options paper to the Remand Working Group for consideration on this matter.

CJI will be returning to this Inspection in due course and would encourage the PSNI and the NIPS to continue to work together to best meet the needs of detainees and ensure organisational resources are used to best effect.

4 See *CJI, Court Custody: The Detention of Persons in the Custody of the Court in Northern Ireland, March 2022,* available at **https://www.cjini.org/TheInspections/Inspection-Reports/2022/Jan-Mar/Court-Custody-2022**.

PSNI staffing, structures and custody estate

Staffing the custody suites had become a greater challenge since the 2019 Inspection fieldwork. Although there was a consistent and experienced group of Custody Sergeants within the PSNI, there were shortages of Civilian Detention Officers (CDOs) to work in the suites, evidenced by the greater numbers of Police Officers (who had been trained as 'Police Gaolers') working in custody either abstracted from LPTs or undertaking a shift as overtime. Inspectors were told that shortages in CDOs available for duty was due to turnover of staff and the need for additional numbers of CDOs to staff the larger Waterside Custody Suite. These issues had been exacerbated by difficulties in recruiting to the CDO role, including budgetary pressures, a limited interest applicant pool and vetting issues. Inspectors noted some variations in the experience and range of duties the Police Gaolers and CDOs could perform. The PSNI advised Inspectors that two training courses for new CDOs would commence shortly, to assist in filling some of the vacancies. In the meantime, the need to fill the gaps with LPT Officers was placing additional pressures on other parts of the PSNI.

In the five years since fieldwork had been conducted for the last Inspection there had been changes to the number and location of operational custody suites as part of a PSNI custody modernisation and improvement plan. A new build custody suite had opened on the site of the Waterside Police Station in Londonderry/Derry for the PSNI North Area, enabling the closure of the custody suite at Strand Road Police Station and the 'mothballing' of the custody suite in Coleraine Police Station. Waterside Custody Suite had a total capacity of 21 cells, although when Inspectors visited during fieldwork it was not operating to full capacity and a further period of closure was planned to rectify some issues within the suite.

Photograph 5

'A' Block corridor, Waterside Custody Suite

Photograph 6

Interior of a cell, Waterside Custody Suite

Photograph 7

Kitchen for preparing detainee meals, Waterside Custody Suite

A custody suite for the PSNI South Area was in planning but was not expected to be completed until 2029. In the meantime, there was an ongoing refurbishment programme and contingency suites were retained to support suite closures at appropriate times. Custody suites in the South Area were smaller, with facilities less suitable for virtual consultations and Court hearings. However, overall, they were well maintained and refurbished to a good standard. For example, Dungannon Custody Suite had recently been painted throughout and detainees were positive about the environment. In the North Area, Antrim Custody Suite showed evidence of attempts to rectify defects in the flooring in the weeks leading up to the fieldwork, where high water levels had led to groundwater rising through the floor of the station custody office.

Photograph 8

Custody desk,
Banbridge Custody Suite

Photograph 9

Kitchen for preparing detainee food, Dungannon Custody Suite

At the time of Follow-Up Review fieldwork in October 2024, there were seven operational custody suites with a current capacity of 81 cells (a further eight located in Antrim were temporarily available on a planned basis as overspill from Musgrave) and a maximum capacity across the whole PSNI estate of 136 cells.

Table 1: PSNI Estate cell capacity (during fieldwork, October 2024)

PSNI Station	Cell capacity
Operational Suites (October 2024)	
Antrim	18 *(10 downstairs and 8 upstairs temporarily available on a planned basis as overspill from Musgrave, 2 cells upstairs were not used)*
Banbridge	7
Dungannon	5
Lurgan	6
Musgrave (Belfast) *(including Terrorism Act cells)*	36 *(plus additional 14 available but closed at time of fieldwork for refurbishment)*
Strabane (mothballed but open during period of Inspection while Omagh was closed)	7
Waterside	10 *(plus additional 11 available but closed at time of fieldwork)*
Total	**89** **(plus additional 27 cells closed during fieldwork)**
Closed Suites	
Coleraine *(mothballed as contingency)*	10
Omagh *(closed for refurbishment)*	10
Total	**136**

As part of a review of the PSNI's organisational structures, the responsibility for Custody Policy and Justice Healthcare had been transferred from within Local Policing to the Service's Justice Department and the two functions had been separated.

At the time of the Follow-Up Review, Justice Healthcare Branch incorporated wider aspects of health care within criminal justice, including the response to vulnerable people under the *Right Care, Right Person* model.[5] The governance arrangements, as described in the 2020 Inspection Report, continued to operate at the time of this Follow-Up Review.[6] These included regular meetings of the Custody Strategic Group and the Custody Operational Group as well as a Custody Policy monthly management meeting. The recommendations from the 2020 Inspection Report had been added to the PSNI's recommendations overview system at the time of publication and then relevant actions had been managed through Custody Policy tasking systems.

Oversight and scrutiny of police custody

In June 2023 the NIPB published its *Human Rights Review* into the strip searching of children and young people in police custody, making eight recommendations for change for the PSNI and two for the DoJ.[7] The report scrutinised guidance and governance frameworks and made recommendations for the PSNI and for The Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE)[8] to ensure protections for young people in custody and appropriate guidance for staff. A recommendation was also made around the use of the Northern Ireland Appropriate Adult Scheme by the PSNI, as a key concern identified in the review was that young people were searched in police custody without an Appropriate Adult being present. In June 2024 an update was provided to the NIPB Performance Committee on the PSNI response to the report. The NIPB noted: '*Police have accepted and put in practice the majority of the Report's recommendations and have actively supported those which require action from the Department of Justice*.'[9]

In the NIPB's *Human Rights Review of Children and Young People and Policing,*[10] published in December 2024, several substantial issues remained regarding the PSNI's compliance with human rights law with the strip searching of children and young people in custody.

During 2023-24 Independent Custody Visitors (ICVs) made 470 visits to custody suites across Northern Ireland. [11] The most frequent matters of wellbeing reported in the 2023-24 *Independent Custody Visiting Report* were related to medical attention, where there was a request by the detainee to see a Health Care Professional (HCP) (26 reports).

5 See **https://www.college.police.uk/article/rcrp-national-guidance-launched**.
6 See Chapter 2: Leadership, Accountability and Partnerships in *CJI, Police Custody, The Detention of persons in Police Custody in Northern Ireland, September 2020,* available at **Police Custody: The detention of persons in police custody in Northern Ireland - CJI NI**
7 *NIPB, Human Rights Review: Children and Young People: Strip Searching in Police Custody, June 2023,* available at **https://www.nipolicingboard.org.uk/publication/human-rights-review-children-and-young-people-strip-searching-police-custody**.
8 See **https://www.legislation.gov.uk/nisi/1989/1341/contents**.
9 *NIPB, Policing Board Chair welcomes police improvements across repeat victimisation and strip searching of young people, NIPB News, June 2024,* available at **https://www.nipolicingboard.org.uk/news-centre/policing-board-chair-welcomes-police-improvements-across-repeat-victimisation-and-strip**.
10 *NIPB, Human Rights Review of Children and Young People and Policing, December 2024,* available at **https://www.nipolicingboard.org.uk/files/nipolicingboard/2024-12/Final%20Human%20Rights%20Review%20of%20Children%20and%20Young%20People%20and%20Policing.pdf**
11 *NIPB, Independent Custody Visiting Report, April 2023 to March 2024, June 2024,* available at **https://www.nipolicingboard.org.uk/files/nipolicingboard/2024-06/Custody%20Visiting%20Statistical%20Report%202024%20-%20PUBLISH.pdf**.

This was followed by detainees requiring an Appropriate Adult (20) or wishing to inform somebody of their arrest (11). There were six allegations or concerns expressed by detainees to ICVs during the year. These covered assault/sexual assault (two), treatment prior to detention (one), treatment in custody (one) medical treatment requested but not noted in the custody record (one) and no response from staff when using the cell call button (one). Fifty-four matters in total were raised by detainees or by ICVs about the conditions of detention including: faulty equipment and general maintenance (25), safety/security hazards (13) cleanliness (four), medical rooms/health equipment (11) and low stock of meals (one).

The Office of the Police Ombudsman for Northern Ireland (OPONI) provided data about complaints and deaths in custody for the purposes of this Follow-Up Review. This confirmed that the majority of complaints that occurred within police custody were related to incidents during the detention of individuals. The overall percentage of complaints about police in relation to custody in the years between 2020-21 and April to August 2024 were small; between 1 and 2% of the total. Over the same period, in cases where a full investigation was completed by the OPONI, the majority of allegations were found to be 'Not Substantiated.' Of the complaints 'Substantiated' or an 'Issue of Concern Identified' Inspectors were advised that there were no specific trends. The incidents related to the use of force, incivility, mishandling of property including theft and issues related to searches.

The OPONI had also made four specific policy recommendations to improve policing and to assist in reducing complaints. One of these was complementary to CJI recommendations (to review refresher training for Custody Sergeants, training for custody staff and consider joint training between custody staff and Health Care Practitioners). Sadly, since CJI's 2020 Inspection Report two people had died while in the custody of the police: one detained in Lurgan Police Station in December 2023 and one detained in Antrim Police Station in September 2024. The OPONI was investigating both deaths at the time of report drafting.

Legislative change

In July 2024 the Minister of Justice announced a consultation on proposed changes to the PACE (Northern Ireland) Codes of Practice.[12] The proposed changes were to Codes of Practice A to H, and the introduction of new Code I. Code C relates to the detention, treatment and questioning of persons by Police Officers and Code H relates to the detention, treatment and questioning of persons under Section 41.[13] The proposed changes in Codes A to H were revisions broadly to reflect changes to primary legislation made by Parliament in the Counter Terrorism and Border Security Act 2019 and the Police, Crime, Sentencing and Courts Act 2022. Code I was a new code which was required to support the National Security Act 2023.

12 *DoJ, Consultation on Police and Criminal Evidence (Northern Ireland) Order Codes of Practice, July 2024,* available *at* https://www.justice-ni.gov.uk/news/consultation-police-and-criminal-evidence-northern-ireland-order-codes-practice#:~:text=Justice%20Minister%20Naomi%20Long%20has,introduction%20of%20new%20Code%20I.

13 *DoJ, PACE Codes of Practice 2015,* available at https://www.justice-ni.gov.uk/articles/pace-codes-practice.

In summary, the proposed changes to Code C (mirrored in Code H) included:

- enable interpretation services to be provided by interpreters based at remote locations using live-link communication technology;
- additional information regarding voluntary suspect interviews;
- new guidance on establishing the gender of persons for the purposes of searching;
- new guidance on Appropriate Adults, including an updated list of who may or may not perform the role;
- additional information to be included on the notice of rights, including information on personal health, hygiene and welfare, and a requirement for female detainees to be asked if they require menstrual products while they are in custody; and
- restructuring of the guidance in relation to strip searching to help clarify the requirements for Appropriate Adults to be present for juveniles and vulnerable persons.

In September 2024 the Minister of Justice introduced the Justice Bill 2024 (the Bill) to the Northern Ireland Assembly.[14] The Bill contained four core aims, one of which was to make changes to bail and custody arrangements for children and young people. This is discussed further in relation to Strategic Recommendation 1. The Bill also included provisions to facilitate the wider use of video and audio-conferencing systems (commonly referred to as live links) within Courts (criminal and civil) and tribunals, thereby allowing the cessation of reliance on similar provisions in the Coronavirus Act 2020. Part 3 therefore specifically related to the use of live links in police custody and intended to make procedural adjustments to PACE detention review provisions by live video link.

Strategic developments

In June 2023 the *Report of the Independent Review of Children's Social Care Services in Northern Ireland*, led by Professor Ray Jones, was published.[15] The report made a number of reflections and recommendations about children's social care in Northern Ireland. Recommendations of relevance to this report were that *'A decision should be taken to introduce a region-wide children's and families Arms-Length Body which includes current HSCTs' statutory children's social care services along with other allied services and professions closely related to children's social care'* (Recommendation 38) and that '*Within the context of developing a region-wide Children and Families Arms-Length Body there should be the development of a regional care and justice centre within the Woodlands [Juvenile Justice Centre – (JJC)] site'* (Recommendation 40). At the time of drafting this Follow-Up Review Report the response from the Northern Ireland Executive to Professor Jones' report and its recommendations was being developed for future publication.

14 *DoJ, Justice Bill takes first steps in Assembly, September 2024,* available at **https://www.justice-ni.gov.uk/news/justice-bill-takes-first-steps-assembly**.

15 *Jones, R. Report of the Independent Review of Children's Social Care Services in Northern Ireland, June 2023,* available at **https://www.cscsreviewni.net/publications/report-independent-review-childrens-social-care-services-northern-ireland**.

Also, in June 2023 the PSNI published a *Children and Young People's Strategy*.[16] This set out how the PSNI intended to meet commitments to children and young people and the people who support and care for them in relation to the five themes of: engagement; safety and protection; suspected offending; victims and witnesses; and stop and search. On the theme of suspected offending, and of relevance to police custody, were the following commitments:

- *you may not be arrested but instead be invited to attend a police station or other agreed location e.g. this may be your home, school or hospital for a voluntary interview;*
- *alternative disposals may need to be agreed with you, and an adult will need to be with you to do so. You will only be taken to a police custody suite after all other alternative disposals are fully considered;*
- *if you are arrested, we will ensure your rights are respected. You will be offered support from a legal representative/solicitor, appropriate adult, or registered intermediary service if required, along with documentation and a prompt investigation by police;*
- *if you are brought into police custody, we will work with partners to minimise the likelihood of being held overnight; and*
- *when you leave custody, we will ensure you understand the next part of the justice process and what will happen and ensure that you are referred to relevant agencies for support.*

The commitment to minimise the likelihood of being held overnight is linked to work delivered in response to Strategic Recommendation 2 as outlined later in this Report.

Changes to health care

A new single digital care record system, *encompass*, had been rolled out across three HSCTs in Northern Ireland at the time of Follow-Up Review report drafting namely the South Eastern HSCT (November 2023), the Belfast HSCT (June 2024), Northern HSCT (November 2024) and subsequently by the Southern and Western HSCTs (May 2025). The system would replace the Northern Ireland Electronic Care Record (NIECR) although NIECR would still be retained as a look-up system. Access to relevant patient information for Forensic Medical Officers (FMOs) had been the subject of a number of previous Inspection recommendations although this had been offset by the expansion of the nurse-led model in police custody suites who had access to the NIECR.

In December 2023 a Coroner found that the tragic deaths of Michael and Majorie Cawdery on 26 May 2017 in their marital home were entirely preventable.[17]

16 *PSNI, Children and Young People's Strategy, June 2023,* available at **https://www.psni.police.uk/about-us/our-strategies-and-vision/children-and-young-people-strategy**.

17 *In the Coroners Court for Northern Ireland, Coroner Maria Dougan, Inquests Touching Upon the Deaths of Lillian Majorie Cawdery and Michael Julien Hope Cawdery [2023] NI Coroner 22,* available at **https://www.judiciaryni.uk/files/judiciaryni/decisions/Inquests%20touching%20upon%20the%20deaths%20of%20Lillian%20Majorie%20Cawdery%20and%20Michael%20Julien%20Hope%20Cawdery.pdf**.

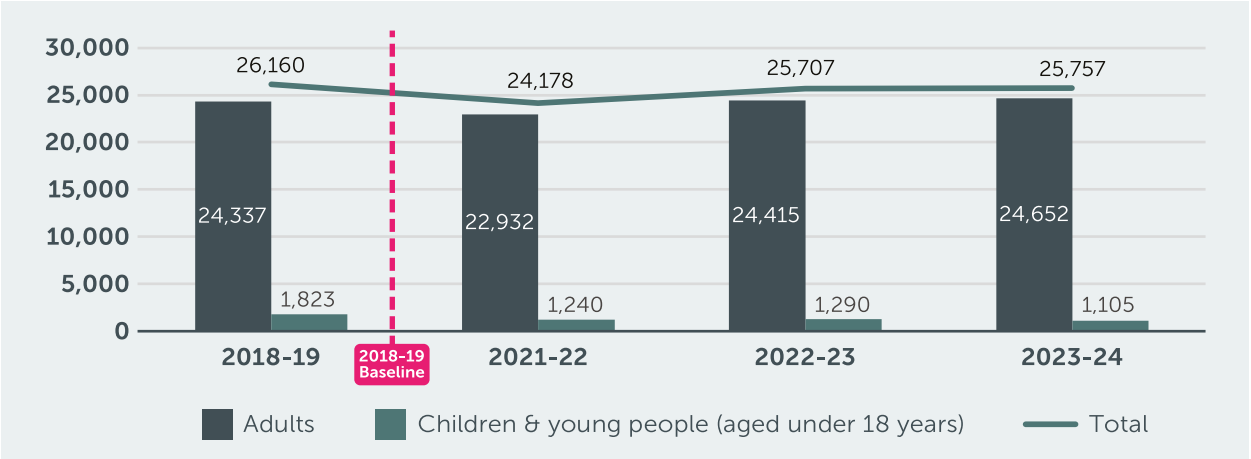
In the inquest findings the Coroner found deficiencies in the consideration of the use of Article 130[18] of the Mental Health (Northern Ireland) Order 1986 by Police Officers as well as other omissions and missed opportunities to alter events and change the outcome in this case. The PSNI had established a co-ordinating group and was contributing to a joint Department of Health (DoH) and DoJ Task and Finish Group to address the shortcomings identified by the Coroner.

Right Care Right Person was an initiative that had been adapted by some police forces in England and Wales to assess and respond to mental health incidents to ensure that vulnerable people get the right support from the right emergency services. The PSNI was working in partnership with the DoH and the DoJ to examine how the *Right Care, Right Person* model could be developed for Northern Ireland. A strategic oversight group jointly led by the DoH and DoJ had been established. Officials from the DoH, DoJ and PSNI gave evidence on the initiative to a Concurrent Committee sitting of the Northern Ireland Assembly Committees for Justice and Health on the model in November 2024.[19]

Detainee population

As shown in Figure 1, PSNI data showed that the overall number of people coming into police custody since 2018-19 had decreased from 26,160 to 25,757 in 2023-24. Adults still accounted for the vast majority of detainees, although the proportion of children had reduced from 7% (1,823 of 26,160 in 2018-19) to 4% (1,105 of 25,757). In the same period there had been an increase in both the number and proportion of females coming into police custody (4,251 - 16% of the total in 2018-19, to 4,646 - 18% of the total in 2023-24.) The profile of detainees by ethnicity was broadly similar (see further discussion under Area for Improvement 1).

Figure 1: Overall totals of detainees in Police Custody from 2021-22 to 2023-24, including breakdown of adults versus children and young people.



18 Article 130 of the Order provides the legal basis for Police Officers to act when they find a person in a public place who appears to be suffering from mental disorder. If an individual is in immediate need of care or control Police are empowered to remove that person to a place of safety.

19 *Northern Ireland Assembly, Concurrent Committee of the Committee for Justice and the Committee for Health, Official Report (Hansard), Right Care, Right Person: DoH; DoJ 7 November 2024,* available at https://data.niassembly.gov.uk/HansardXml/committee-34166.pdf.

CJI and RQIA's Follow-Up Review

The Follow-Up Review was formally announced in July 2024 and a progress update was requested from the DoJ and the PSNI. The PSNI co-ordinated responses from the Belfast HSCT. CJI invited stakeholders who had an interest in police custody to comment on progress against the recommendations. The Northern Ireland Commissioner for Children and Young People (NICCY) and the OPONI provided information to Inspectors for this purpose. CJI also met with a group of ICVs from across the monitoring teams in Northern Ireland.

The self-assessment material was reviewed and Follow-Up Review fieldwork was mostly conducted during one week in early October 2024. Documentation provided by the PSNI and Belfast HSCT included policies, procedures, training materials, records of audits conducted by Custody Policy Branch and data and performance information. The initial self-assessment response provided by the PSNI is included within the body of this report. A sample of custody files were audited to support Inspectors assessment of specific recommendations. Senior leads for police custody within the PSNI and Belfast HSCT were interviewed and a focus group was conducted with Custody Sergeants from custody suites across Northern Ireland. Teams of Inspectors from CJI, RQIA and the NIPB Human Rights Team visited six of the seven operational custody suites and met custody staff, spoke to detainees, made observations of the facilities and care provided and sampled records.

CHAPTER 2: PROGRESS AGAINST 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).**

Status: Partially achieved.

Organisational response

The Department has finalised draft provisions in relation to children's bail, remand and custody for inclusion in the Justice Bill. This Bill was introduced to the Assembly on 17 September and passed Second Stage on 1 October. The bail and remand provisions aim to address recommendations not only from the Law Commission report published in 2012, but also the Youth Justice Review 2011 and recommendations from other relevant reports into youth justice. The new provisions will also enhance compliance with Article 37(b) of the United Nations Convention on the Rights of the Child (UNCRC) to ensure that custody for children should only be used as a measure of last resort and for the shortest appropriate period of time.

In addition to legislating for a statutory right to bail and introducing new tests which must be met before a court can remand a child into custody, the provisions also update PACE legislation to reflect the need to consider a range of factors when deciding whether or not to release a child on bail following arrest. These include the child's age, maturity and understanding. A further provision, once commenced, will prevent a child from being held in custody solely on the basis of a lack of suitable accommodation in the community. This was also a recommendation within the Law Commission's report. Whilst the responsibility for providing such accommodation sits with the DoH, the DoJ will continue to engage with Health colleagues within relevant fora in order to progress this issue.

The DoJ assessed this recommendation as achieved.

Inspectors' assessment

In November 2021 the NICCY gave oral evidence to the Committee for Justice in relation to the Justice (Sexual Offences and Trafficking Victims) Bill. The Commissioner stated, '*I am deeply disappointed that the intended scope of the planned Miscellaneous Justice Bill has not been brought forward, particularly in relation to children who are involved with the criminal justice system, and regret the lost opportunities to address those important issues within the current mandate*.'[20] The supporting written submission reiterated '*the Commissioner is deeply disappointed that the intended scope of the planned Miscellaneous Justice Bill have not been brought forward, particularly in relation to bail and remand reform and the Minimum Age of Criminal Responsibility and highlights the lost opportunities to address these important issues within the current mandate*.'[21] The NICCY has long expressed concerns about the use of Woodlands JJC as a place of safety under PACE.[22]

In September 2024 the Justice Bill 2024 (the Bill) was introduced to the Northern Ireland Assembly.[23] The Bill proposed to make changes to bail and custody arrangements for children and young people. Part 2 contained provisions relating to bail, remand and custody for children, to:

- strengthen the existing presumption of bail for children, introducing unconditional bail as standard and a requirement that any conditions applied should be proportionate and necessary;
- introduce specific conditions which must be met before a child can be remanded into custody; and
- underpin the current administrative arrangements which exist around the separation of children and adults in custodial settings.

Specifically, the Bill proposed to amend Article 39 of the PACE (Northern Ireland) Order 1989 so that the Custody Officer, in taking a decision whether to release an arrested juvenile from police detention, either on bail or without bail, '*may consider the juvenile's accommodation needs but must not refuse to release the juvenile on bail solely because the juvenile does not have any or adequate accommodation*.' It made a similar amendment to the Criminal Justice (Children) (Northern Ireland) Order 1998 in relation to the decision of a Court to refuse bail.

20 *Northern Ireland Assembly, Official Report: Minutes of Evidence: Committee for Justice, meeting on Thursday, 11 November 2021,* available at **https://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?AgendaId=29190&eveID=14900**.

21 *NICCY, Justice (Sexual Offences and Trafficking Victims) Bill Written submission to the Justice Committee, 24 September 2021,* available at **https://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/justice/primary-legislation/justice-etc-bill/20210924-niccy.pdf**.

22 See for example *NICCY, Custodial arrangements for children in Northern Ireland: Advice to the DoJ, August 2013,* available at **https://www.niccy.org/wp-content/uploads/2022/03/niccy-response-to-custodial-arrangements-august-2013.pdf**.

23 *DoJ, Justice Bill takes first steps in Assembly, September 2024,* available at **https://www.justice-ni.gov.uk/news/justice-bill-takes-first-steps-assembly**.

Plans to include provisions addressing bail for children in a Justice Miscellaneous Provisions Bill in 2021 were not progressed as a decision was taken to introduce a more narrowly scoped Bill in its place at that time. Instead, the children's bail and remand provisions were included in the Justice Bill introduced in the Assembly in September 2024. Following introduction, the DoJ advised that there had been a request by the Committee for Justice to extend the Committee scrutiny period to 18 months. This request was debated in the Northern Ireland Assembly on 5 November 2024 when it was agreed that the Committee Stage of the Bill be extended to 26 March 2026. This meant it was unlikely to receive Royal Assent until late in 2026.

At the time of Follow-Up Review fieldwork there had not been alternative accommodation arrangements developed, particularly for 'Looked After'[24] children. The DoJ advised that opportunities to explore alternative accommodation options were being taken through officials' representation on a number of groups, and that a bail fostering scheme was being piloted by the Southern HSCT. The outcomes of the Professor Ray Jones' Independent *Review of Children's Social Care Services* (as outlined in the Introduction to this report) was also likely to have an impact on how young people in, and leaving custody, would be supported.

The PSNI had been consulted on the changes proposed in the Justice Bill but had been advised that the specific provisions that related to bail and accommodation in relation to children (Clause 8) would be commenced by Order and not on Royal Assent. This would be delayed until suitable alternative accommodation was available, in addition to Woodlands JJC, and Woodlands continued to be used under PACE for children at the time of fieldwork (see the PSNI response to Strategic Recommendation 2). The PSNI were seeking to clarify how Custody Officers would assess the 'maturity' of a child which was required in the considerations for authorising detention after charge.[25]

Inspectors welcomed the introduction of this Bill to address the issue of bail for children and young people and look forward to its passage through the various stages of the legislative process. Given the length of time likely to pass before the Bill receives Royal Assent, CJI would encourage all partners to work together to ensure that arrangements are in place by the time it is enacted to provide alternative arrangements for young people in police custody, particularly those who are 'Looked After' by a HSCT. This is an issue Inspectors will return to in future inspections of police custody.

Inspectors assessed this recommendation as **partially achieved**.

24 The DoH 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 **https://www.health-ni.gov.uk/articles/looked-after-children**.

25 See *Part 2, Children: Bail, Duties of custody officer after charge, Article 4 of Northern Ireland Assembly, Justice Bill, as introduced, September 2024,* available at **https://www.niassembly.gov.uk/assembly-business/legislation/2022-2027-mandate/primary-legislation-bills-22-27-mandate/justice-bill/bill---as-introduced/**.

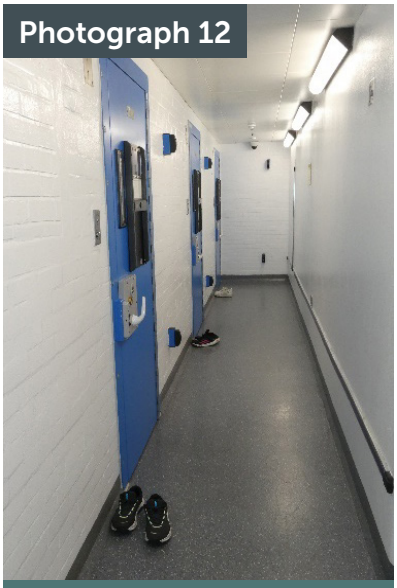
Photograph 10

Cell interior, Musgrave Custody Suite

Photograph 11

Cell corridor, Musgrave Custody Suite

Photograph 12



Cell corridor, Dungannon Custody Suite

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).

Status: Partially achieved.

Organisational response

The PSNI have conducted work with the DoJ to problem solve the issue of 'Looked After' children being held in police custody. The PSNI are represented at the Regional Facilities for Children and Young People Programme Board. All overnight detentions of juveniles who have Social Services involvement are reviewed to establish if there are legitimate reasons why a child was not accommodated in a place other than custody. Longer term, proposed amendments to the Criminal Justice (Children) (NI) Order 1998 (specifically Clause 8 [j309] - prevents a child from being detained in custody and refused bail (whether that is police bail or court bail) solely because of the absence of any, or adequate, accommodation, where all other considerations for the granting of bail have been met. In recognition of difficulties around this issue, this amendment will not be commenced immediately, but held until community accommodation provision is improved, [sic: and] will support this recommendation.

The PSNI assessed this recommendation as partially achieved.

Inspectors' assessment

As outlined in relation to Strategic Recommendation 1, the PSNI had been consulted about the proposed changes to the legislative provisions relating to bail, although it was not anticipated that any alternative accommodation for children would be available in the near future. Woodlands JJC therefore continued to be the only accommodation available when HSCTs advised that there was no other accommodation for a child.

The PSNI Custody Policy Branch had been represented on both the Regional Care and Justice Programme and the Youth Champions Forum. Discussions had been held at Regional Care and Justice Programme Working Group meetings about children who were Looked After by a HSCT. Inspectors were advised that issues discussed included children being held in custody overnight, alternative accommodation for children and monitoring of guidance for social services on supporting looked after children in the criminal justice system. The Working Group had held its final meeting in February 2024, after which the Programme was closed.

PSNI Custody Policy Branch were represented on the Youth Champions' Forum alongside those from other Branches in the PSNI, the Youth Justice Agency (YJA), HSCTs, the Safeguarding Board for Northern Ireland and from children's rights and Voluntary and Community Sector organisations. Inspectors were told that the Forum provided an opportunity to discuss issues around children 'Looked After' by a HSCT and resident in a children's home. Although there had been engagement work to increase the understanding that issues in children's homes were not always appropriate for the police to resolve, it was acknowledged by the PSNI that there was more work to be done on how to manage such incidents.

As outlined in the introduction to this report, data indicated that there had been a reduction in the number of children coming into custody from 1,823 in 2018-19 (7% of the custody population) to 1,105 in 2023-24 (4% of the custody population). Custody staff also advised Inspectors that the numbers of children coming into custody had reduced, with staff in some custody suites stating that they rarely had children in custody. Where issues remained, these tended to relate to the arrest and detention of children who were resident in children's homes and concerns remained about the ability to have the case dealt with and the child released, primarily down to delays in obtaining an Appropriate Adult, particularly at night. For the 2020 Inspection Report CJI utilised figures published by the then Health and Social Care Board (now the Strategic Planning and Performance Group) relating to the reporting of 'untoward incidents' by HSCTs involving a child in care. This data had not been published since the functions of the Health and Social Care Board were transferred to the DoH in 2022.

Data published by the YJA showed there were 180 admissions under PACE to Woodlands JJC in 2023-24. Although this was a slight decrease from 2019-20 (197 admissions) it formed a greater proportion of the total population of those held in Woodlands JJC under PACE (84.1% of total admissions in 2023-24 versus 66.1% of admissions in 2019-20.)[26]

26 *YJA, Northern Ireland YJA Annual Workload Statistics 2023-24, September 2024,* available at **https://www.justice-ni.gov.uk/publications/youth-justice-agency-annual-workload-statistics-2023-24**.

In addition, the proportion of children admitted to Woodlands JJC who were subject to a Care Order (and therefore a 'Looked After' child) had increased from 30.9% in 2019-20 to 49.1% in 2023-24 (although data was only published for all children admitted, rather than just those under PACE).

PSNI Custody Policy Branch undertook monthly audits of all children held in custody overnight, which included reviewing the numbers transferred to Woodlands JJC. The review of custody records by CJI identified some positive practice by Custody Sergeants in relation to decisions not to authorise detention where children were brought to custody, directions to avoiding placing the child in a cell or cases being expedited. Although a small sample, there continued to be some evidence of difficulties in getting a Social Worker to act as an Appropriate Adult for the child, causing the child to be held overnight or delays in their interview and release.

Data showed that the focus by the PSNI on diverting children away from custody had resulted in improvements in the number being held in police custody. However, there was still evidence from YJA data and CJI's fieldwork that children who are 'Looked After' by HSCTs are held in custody overnight and for too long, or transferred to Woodlands JJC due to an inability to return home or a lack of alternative accommodation. To fully address this recommendation the PSNI would need to evidence a specific reduction in the number of 'Looked After' children held in custody. The available data will be important for the PSNI to continue to hold conversations with partners about the lack of alternative accommodation for children, particularly those who are 'Looked After.' This will be an ongoing issue for the PSNI to manage and engage with partners to address until alternative accommodation, recommended in Strategic Recommendation 1, is made available for children in custody.

Inspectors therefore assessed this recommendation as **partially achieved**.

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.)
Status: Partially achieved.

Organisational response

The PSNI, the Belfast HSCT, the Public Health Agency (PHA), the DoH and the DoJ are working collaboratively to deliver a transformed custody healthcare service.

To date this project has delivered the 'pathfinder' in Musgrave Custody Suite where Custody Nurse Practitioners (CNPs) have been delivering healthcare since autumn 2018.

In early 2022 an outreach of this service was extended to Antrim Custody Suite and most recently in late November 2023 a nurse-led custody healthcare service has been delivered within a new build Custody Suite at Waterside in Derry/Londonderry.

A Strategic Custody Healthcare Group, including all partners and chaired by the PHA and the PSNI provides oversight of this collaborative project. This group initially met on 06/02/24 and has since met regularly. These meetings are minuted including a review of any actions. The last meeting was held on 13/05/24.

The Belfast HSCT are responsible for the governance and leadership of the nurse-led model, including staffing, training, services, equipment and medicines management.

The nurse-led model in Musgrave and Waterside Custody Suites provides an embedded 24/7 custody healthcare service. Antrim Custody Suite was established as an outreach from Musgrave Custody Suite with CNPs providing 24/7 custody healthcare service. The embedded nursing service in Musgrave Custody Suite includes a Registered Mental Health Nurse. All CNPs complete the Faculty of Forensic and Legal Medicine (FFLM) General Forensic Medicine Course.

In addition to achieving the objective of standardisation and strengthening of clinical governance arrangements for custody healthcare, the Belfast HSCT custody healthcare team has delivered significant healthcare outcomes, beyond the PSNI's statutory obligations under PACE, including:

- *brief alcohol interventions;*
- *arranging follow-up appointments with Community Mental Health Teams; and.*
- *the use of clinical opiate warning scores and the Glasgow modified alcohol warning score regarding the level of withdrawal from opiate drugs and/or alcohol and provision of advice for substance misuse.*

Minor injuries are also assessed and treated in custody, avoiding the need for removal of detained people with a minor injury to an Emergency Department (ED).

Additionally, the following improvements to population health outcomes are being delivered by the Belfast HSCT:

- *testing for blood borne viruses in high risk groups;*
- *maintenance of opioid substitution therapy;*
- *improved medicines concordance;*
- *clean needle provision;*
- *referrals into voluntary and statutory services; and*
- *signposting for take home Naloxone.*

The full realisation of the delivery of a regional model has been slower than originally anticipated for a number of reasons. This includes the impact of the Covid-19 pandemic and a delay in the opening [of] Waterside Custody Suite.

Waterside Custody Suite has not yet opened to its full capacity as a 21-cell custody facility. However, consideration regarding further expansion of this project, including the agreement of an appropriate funding model will be considered by a subgroup of the strategic group and plans to meet in late summer 2024. Once agreed it is anticipated that phase 3 of this project will include: Omagh, Dungannon, Banbridge and Lurgan Custody Suites.

The introduction of the nurse-led model in Musgrave, Antrim and Waterside Custody Suites has been successful with high numbers of nurses reporting job satisfaction. Police custody staff reported significant improvements due to the nurse-led model; assessments and treatments were timely and more robust. A clear system of clinical leadership and governance, with a clear line of staff management and accountability is in place in the suites with the nurse-led model. All nurses have undertaken forensic training to enable them to undertake their role. This governance is not in place at the suites with the FMO-led model. Feedback from custodial staff and wider stakeholders highlighted the nurse-led model as the most effective and safe for people who have been detained. Consideration should be given at the soonest opportunity to the roll out the nurse-led model wider across all of the Northern Ireland custody suites to ensure equity of care.

The PSNI assessed this recommendation as partially achieved.

Inspectors' assessment

The Belfast HSCT remained responsible for the governance and leadership of the nurse-led service, including the recruitment of nursing staff to this service.

The previous Inspection carried out in December 2019 evidenced one nurse-led service at Musgrave Custody Suite. Since December 2019 the nurse-led service in Musgrave had been extended to Antrim Custody Suite and a further nurse-led service had been commissioned and was operational in Waterside Custody Suite. However, this service was still not available in the remaining custody suites with the health needs of the detainees being met by FMO-led services.

The custody suites that had a nurse-led service resulted in better health care outcomes for detainees. Identification of health needs and any subsequent care and treatment required was available quicker than for those detainees in custody suites where a nurse-led service was not available.

All key stakeholders agreed there was a need for the nurse-led service to be progressed further, and while there were plans to roll-out this service in two phases to other custody suites, there was limited evidence to demonstrate effective collaborative working to expedite the implementation of the nurse-led service across Northern Ireland with interdepartmental strategic support. Funding constraints were reported to have hindered progress.

Photograph 13

Intoxilisor machine, Banbridge Custody Suite

The rollout of the nurse-led service should be expedited to ensure the benefits of this service are available to all detainees and reduce the risks to detainees, staff and wider public safety in custody suites where this is not available.

Inspectors assessed this recommendation as **partially achieved**.

Photograph 14

Medical Room, Banbridge Custody Suite

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).

Status: Partially achieved.

Organisational response

The Belfast HSCT and the PSNI participate in a weekly operational meeting, this includes the Belfast HSCT Lead Nurse, Custody Inspectors and Justice Healthcare Branch. This forum also includes representation from the PSNI's Health and Safety Branch, learning arising from E23/10 and Datix is regularly discussed at these meetings. Additionally, the Lead Nurse Belfast HSCT is in regular contact with the PSNI's Head of Health and Safety.

Complaints are rare, however the Belfast HSCT has agreed a short complaints handling protocol with the PSNI for the joint investigation of complaints.

The PSNI assessed this recommendation as partially achieved.

Inspectors' assessment

Separate policies were in place for health care and custody staff to follow when managing incidents and/or complaints. FMOs were not included in either of these policies and/or procedures. Both custody staff and health care staff were knowledgeable about these and were aware of what action to take if a detainee made a complaint about either custody or health care staff, if they were involved in an incident.

Custody staff offered detainees the opportunity to raise complaints at the point of exiting custody suites. In cases where the complaint was in relation to health care the Belfast HSCT complaints leaflet was provided. Complaints involving custody staff were escalated and referred to the OPONI.

A system had been developed and implemented for the joint analysis of incidents/complaints and identification of shared learning. This system only involved the custody staff and health care staff. FMOs were not included in this system which was a missed opportunity to share learning. The PSNI advised that complaints regarding the practice of a FMO were managed on a case-by-case basis. Initially complaints were referred to the Administrative FMO for consideration, but PSNI Justice Healthcare Branch also had the ability to escalate to seek wider peer review.

Incidents involving delays in patient access to an inpatient mental health assessment were not escalated appropriately. Access to an Approved Social Worker, for the purposes of completing an Application for Admission for Assessment under the Mental Health (Northern Ireland) Order 1986, was not always completed in a timely way, and this impacted on the length of time a detainee had to wait on an admission to a Mental Health Inpatient hospital.

When delays happened, there was no evidence of escalation to the relevant agencies. Systems should be developed and implemented to escalate shortfalls in service provision, to improve timely access to mental health services and achieve better outcomes for detainees.

Inspectors assessed this recommendation as **partially achieved**.

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).
Status: Not achieved.

Organisational response

The requirements outlined in this recommendation requires a system of clinical governance, which is lacking in the current model of independently contracted FMOs. Therefore any complaints to date are reviewed in an ad-hoc manner.

The Transformation of Custody Healthcare project concentrated on the delivery of a nurse-led service. However, Justice Healthcare Branch has held an initial meeting with an associate of the Faculty of Forensic and Legal Medicine (FFLM) and the Belfast HSCT regarding the role of an FMO in a nurse-led service and plans to meet again in autumn 2024. The PSNI is seeking assistance from the FFLM in potentially sourcing Doctors to provide the role of FMO.

The PSNI assessed this recommendation as not achieved.

Inspectors' assessment

The provision of the FMO service was delivered inconsistently and lacked a focused approach to drive quality improvement. Since the previous Inspection, no formal systems had been developed to allow PSNI, custody staff and health care staff to escalate concerns relating to FMO's practice.

Difficulties recruiting and retaining FMOs meant that custody health care was not being provided consistently. For example, during one on-site visit Inspectors were advised that the FMO on call had instructed custody staff to administer medication to a detainee despite not having visited or spoken to them by telephone or video call. The custody staff were concerned about the risks this presented to both the detainee and staff. The potential risk for detainees by not having continuous access to health or medical care in the Southern District had been escalated to the Assistant Chief Constable and Departmental Risk Management group, however, there was limited evidence to indicate the PSNI had taken action to address this deficit. This had been identified as a risk on the Justice Healthcare risk registers.

The FMO-led service was also not sufficiently responsive to support the criminal justice process. For example, Inspectors were advised of cases where FMOs had not attended the custody suite or a local hospital, within an appropriate timescale, to take blood samples from a driver suspected by police (on the basis of a preliminary test) to be driving under the influence of excess alcohol or drugs. Inspectors were told this had led to situations where detainees had been released without charge as such delays meant that it was not possible to prove excess alcohol or drugs through an evidential test (a sample of blood) for the purposes of a prosecution file. Potentially this meant that individuals who had driven under the influence of excess alcohol or drugs may not be held to account for their actions and were able to re-offend and potentially cause harm. This created a risk to public safety. The Chief Inspector and Lead Inspector discussed this concern with an Assistant Chief Constable and Justice Healthcare Branch staff who agreed to carry out further analysis of the impact of current service provision on evidence gathering and prosecution.

Following Follow-Up Review fieldwork, an associate of the FFLM visited Northern Ireland on a fact-finding visit to understand the current FMO provision. The outcome of this visit identified that the model in place was not consistent with the current role of the forensic physician. A number of recommendations on how the FMO service could be remodelled to enhance improved governance were made. Inspectors will continue to monitor the development of, and governance arrangements for, the FMO service in future inspections of police custody. As FMOs will continue to be utilised within a fully rolled out nurse-led model, it is important that the PSNI develop plans for a remodelled service, utilising this advice and support.

This Follow-Up Review identified Strategic Recommendation 3 had not progressed. The absence of a robust clinical governance framework for FMOs remains a concern. The PSNI should urgently consider what interim arrangements can be put in place pending the expansion of the nurse-led model.

As noted in relation to Strategic Recommendation 3, the rollout of the nurse-led model should be expedited at pace, given the potential risk for detainees and staff in custody suites and wider public safety where health care is only provided by the FMO service.

Inspectors assessed this recommendation as **not achieved**.

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 which should be clearly communicated to health care professionals working in these environments (paragraph 5.87).

Status: Achieved.

Organisational response

CNPs, employed by the Belfast HSCT, screen all detainees for mental illness as part of their assessment process. If it is deemed through assessment that an individual requires further interventions in relation to their mental health, this can be addressed by embedded Mental Health Practitioners within Musgrave Custody Suite. The Belfast HSCT has liaised with the Northern HSCT and the Western HSCT and has arranged for the Crisis Response Team to attend in Antrim Custody Suite if further assessment is required. Waterside Custody Suite at present avails of Crisis Response Team within the ED in Altnagelvin Hospital.

In, Dungannon, Banbridge and Lurgan Custody Suites, the FMO can consult with the Crisis Response Teams who can attend and carry out a mental health assessment. In Waterside and Strabane Custody Suites conversations are still ongoing to achieve this too but the current process is; if concerns are raised the detained person can attend an ED and get a general mental health assessment by Crisis Response Teams.

Justice Healthcare have developed guidance for custody staff and healthcare staff relating to mental health in custody. It is anticipated this document will be disseminated imminently (next 4 weeks). This guidance covers processes for those who come to custody detained under Article 130 Mental Health (Northern Ireland) Order 1986 and for those who are in custody and issues with their mental health has been identified during the criminal justice process.

During the financial year 01/04/23 – 31/03/24, there were 25,395 detentions in PSNI custody. Waterside Custody Suite opened in late November 2023 therefore during that financial year, 65% of people detained in custody had access to the nurse-led service.

However, the subsequent closure of Coleraine and Strand Road Custody Suites effectively means that 76% of people detained in PSNI custody suites now have access to the nurse-led service and the improvements which accompany this service.

The PSNI assessed this recommendation as achieved.

Inspectors' assessment

The Follow-Up Review found that there were good arrangements for access to acute mental health care for patients and a pathway throughout all custody suites to guide staff.

Custody Sergeants demonstrated the ability to identify if a detainee was mentally unwell and described the action they would take. Although the pathway may differ depending on the location of police custody suites, all detainees had appropriate access to acute mental health care through the HSCT with access to Home Treatment Crisis Response Teams.

Following recommendations from a Coroner's report, the use of Article 130 Mental Health (Northern Ireland) Order 1986 is currently under review (see Introduction for further detail).

Inspectors assessed this recommendation as **achieved**.

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).
Status: Not achieved.

Organisational response

Collection of Section 75 data is on a voluntary basis only. Custody officers will ask detainees what religion they are and advise the detainee that this is being asked for equality monitoring purposes. Sexual orientation is not recorded as part of the custody process. The PSNI are currently undertaking a Community Background Project to increase the level of recording, with a pilot underway initially looking at Stop and Search. The findings and methodology of this will be extended across the service if successful, including the custody process.

The PSNI assessed this recommendation as partially achieved.

Inspectors' assessment

The PSNI confirmed that this recommendation had been closed in June 2021 on their overview monitoring system due to the rationale outlined in the response above; that an extension to the collection of Section 75 data[27] to include community background or sexual orientation would have human rights implications and would be stepping outside of guidance from the National Police Chiefs' Council (NPCC) as well as requiring an upgrade to the Niche™ Records Management System.[28]

27 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. See **https://www.legislation.gov.uk/ukpga/1998/47/section/75**.

28 The PSNI uses a records management system supplied and supported by Niche Technology Incorporated.

The lack of monitoring community background by the PSNI had also been commented on by other scrutiny bodies, researchers and the media, which was summarised recently in the NIPB *5 Year Human Rights Review*, published in June 2024.[29] The report recommended that '*The PSNI should report to the Board on progress on the changed approach to data collection in relation to community background, the data that has resulted, and any proposed substantive action it intends to take and publish the data in due course*.' The report noted concerns about imbalances in the community background of those subject to 'stop and search' processes, as well as arrests and charge by the PSNI. In response to this, and previous recommendations, a pilot project had commenced to monitor the community background of those who were subject to stop and search.

However, as highlighted to Inspectors by the NICCY, this was restricted to those stopped under the stop and search powers of the Justice and Security (Northern Ireland) Act 2007,[30] and therefore did not extend to stop and search powers under PACE[31] or under the Misuse of Drugs Act (1971).[32] This pilot therefore related to less than a quarter of those stopped and searched by the PSNI.[33] It will also have particularly limited impact in relation to the monitoring of stop and search of those aged under 18 years, given that the legislative powers used most against children and young people were not included.

Inspectors were advised during this Follow-Up Review that the pilot was currently underway. However, at the time of report drafting, there was no indication as to whether it would be extended to other stop and search powers, become business as usual for stop and search monitoring or if it would be rolled out to other areas of policing where Section 75 data is recorded, including custody.

In addition, the NIPB *5 Year Human Rights Review* report also noted disproportionality in the religious background of the 84 individuals on whom a 'spit and bite guard' was deployed by the PSNI between 16 March 2020 and 31 December 2020. The figures show the religious background of almost half those individuals as being 'Roman Catholic' (48%); with the remaining half being recorded as 'Protestant' (20%); none (16%); refused/unknown (16%); Other Christian (3%) and 'Buddhist' (3%). The report noted: '*It is assumed that these figures were collated from the answers to the question set out above, asked when the person arrives in custody*.'

29 *NIPB, Human Rights 5 Year Review, June 2024,* available at **https://www.nipolicingboard.org.uk/files/nipolicingboard/2024-07/Human%20Rights%205%20Year%20Review%20-%20Final.pdf**.

30 See *Section 21, Stop and question and Section 23, Search for munitions and transmitters,* **https://www.legislation.gov.uk/ukpga/2007/6/section/21**.

31 See *Section 3, Power of constable to stop and search persons, vehicles etc.* **https://www.legislation.gov.uk/nisi/1989/1341/contents**.

32 See *Section 23, Powers to search and obtain evidence* **https://www.legislation.gov.uk/ukpga/1971/38/contents**.

33 In 2023-24 68% of stops were conducted under the Misuse of Drugs Act* and 11% of stops were conducted under PACE*, 17% of stops were conducted under the Justice and Security Act Section 24* and 3% under the Justice and Security Act Section 21 *(* alone, or in combination with other powers). PSNI, Use of Stop and Search Powers by the Police in Northern Ireland 1 April 2023 to 31 March 2024, May 2023,* available at **https://www.psni.police.uk/sites/default/files/2024-05/PSNI%20Stop%20and%20Search%20Report%20Q4%202023_2024.pdf**.

This approach to monitoring conflated two Section 75 monitoring categories proposed by the Equality Commission for Northern Ireland; that of religious belief (which includes asking individuals about their religion, religious denomination or religious body with responses including Roman Catholic, Presbyterian Church in Ireland, Church of Ireland, Methodist and other Christian and non-Christian religions) with community background (with possible responses that the individual is a member of the Protestant community, Roman Catholic community or neither.)[34] Roman Catholic is both a community background category and a religious belief category whereas Protestant is not. This may therefore lead to records which increase the likelihood of a perception of greater disproportionality when asking about religious belief rather than community background.

In England and Wales, the Equality Act 2010 was introduced to harmonise discrimination law, and to strengthen the law to support progress on equality.[35] The Act set out nine characteristics that are protected by subsequent provisions in the Act and it is these 'protected characteristics' that form the basis for monitoring by public bodies. Although therefore England and Wales operated under different legislation to that in Northern Ireland, the characteristics were broadly similar, however it should be noted that there was no characteristic relating to community background as it is defined in Northern Ireland.

In March 2023, the NPCC and College of Policing published the *Protected Characteristics: Operational Recording Data Standard*.[36] This noted that '*The aims of the standard are to provide policing with consistent values by which to record protected characteristics. The ambition is that the standard will be applied to both current record management and operational systems and future systems and will evolve as legislation, societal expectations and recording standards change*.' It highlighted the five core principles for recording data on protected characteristics as follows:

1. *Policing adopts a national standard for the recording of all protected characteristics;*
2. *As far as possible, policing aligns with existing national recording standards;*
3. *The context (the why) in which policing should record each characteristic should be determined and national guidance provided;*
4. *Standards should be annually reviewed to ensure that they continue to be correct and proportionate; and*
5. *People who come into contact with the police have a right to the accurate recording of relevant characteristics.*

34 See *Equality Commission for Northern Ireland, Section 75 of the Northern Ireland Act 1998: Monitoring Guidance for Use by Public Authorities, July 2007,* available at **https://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/S75MonitoringGuidance2007.pdf**.

35 See **https://www.legislation.gov.uk/ukpga/2010/15/contents**. The nine protected characteristics are age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

36 *College of Policing and National Police Chiefs' Council, Protected Characteristics: Operational Recording Data Standard, Version 1 - 31st March 2023,* available at **https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/disclosure-logs/dei-coordination-committee/2023/244-2023-appendix-b-protected-characteristics-operational-recording-data-standard-version-1-31st-march-2023.pdf**.

This data standard provided guidance to Police Chiefs on how to record sexual orientation. As the PSNI usually followed guidance provided by the NPCC and College of Policing, it would be expected that the monitoring of sexual orientation would have been included for consideration and implementation.

The NICCY also highlighted gaps across publicly available information about children in police custody with existing reports from the PSNI not disaggregated by age. For example, annual statistical reports relating to PACE include a breakdown of those searched and arrested, as well as a gender breakdown but did not appear to accessibly publish statistics relating to age. The NICCY also noted a lack of clarity in the publicly available data as to how many children and young people were in police custody annually.

Inspectors hope that the pilot for collection of community background for stop and search is the first step in a process to expand the monitoring of Section 75 data. CJI would encourage the PSNI to re-consider its decision not to collect data on sexual orientation in light of the College of Policing and NPCC guidance.

However, at the current time Inspectors assessed this recommendation as **not achieved.**

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).
Status: Partially achieved.

Organisational response
Guidance based on Authorised Professional Practice (APP) was shared with custody staff. The lesson on care plans delivered during initial staff training was reviewed in line with APP. Custody Policy, as well as Custody Inspectors, perform monthly audits of dip-sampled custody records. Review of care plans forms part of the audit. This in turn forms part of the performance framework for custody. Where non-compliance is identified, this is addressed with the officer.

The PSNI assessed this recommendation as achieved.

Inspectors' assessment

Inspectors were provided with a copy of guidance issued to custody staff in March 2020 specifically on the topic of care plans and observations. This guidance, based on the College of Policing's *Detention and Custody Authorised Professional Practice* module,[37] highlighted the responsibilities of the Custody Sergeant for managing the supervision and level of observation of detainees, keeping a written record in the custody record and specifically checking that Police Officers and staff adhere to the timings of observations and carry out rousing as required by the four levels of observation (see Table 2 for a summary of these levels.) The four levels of observation were reinforced, including the need to consult with the HCP for their recommendations and emphasised the need to review and update care plans at appropriate intervals. Training material for Custody Officers emphasised this approach including the need for Level 2 rousing to be positive communication at frequent and irregular intervals. The PSNI advised that the topic of care plans was on the agenda for the next annual Continuing Professional Development day for Custody Officers planned for the end of 2024.

Custody staff spoken to during fieldwork all demonstrated an understanding of the levels of observation and their requirements, particularly the need to rouse detainees placed on Level 2. They also pointed to the discussions with, and recommendations of, the HCP as an important aid to their decision-making. In most visits conducted, Inspectors saw that detainees were placed on the appropriate level of observation and saw evidence of detainees on Level 2 being roused. Inspectors observed one instance of a detainee who had been reduced from Level 2 to Level 1 but whose demeanour suggested that they had deteriorated and needed a greater level of observation. This was actioned by the Custody Sergeant during the visit.

Inspectors found examples of effective risk assessment and care planning within the custody records reviewed, as well as some records of rousing which met the requirements of the College of Policing APP module in terms of recording positive communication with the detainees. However, there was still evidence of too many records where the care plan lacked detailed analysis of the risks presented, Level 2 care plans which did not specify the need to rouse the detainee or noted 'no need to rouse' or where records showed checks undertaken when the detainee appeared asleep with no written evidence that detainees had been roused. Inspectors saw some records where care plans had been reviewed following an assessment from the HCP or based on their advice to reduce the level of observation after a period of time, but there was still evidence of detainees who were kept on Level 2 for the entire duration of their time in custody.

The PSNI provided evidence from their own audits of care plans, undertaken by Custody Inspectors and by Custody Policy Branch. Inspectors were advised that recurrent themes were identified from these audits for the purposes of identifying training needs or performance issues relating to individual Officers. Evidence from these audits had led to the decision to include this issue in the next annual Continuing Professional Development

37 *College of Policing, Authorised Professional Practice: Detention and Custody, October 2013 (updated October 2024),* available at **https://www.college.police.uk/app/detention-and-custody**.

day. This demonstrated an ongoing commitment to reinforcing the quality of risk assessment and care planning but also confirmed the findings of CJI's custody record reviews.

Table 2 showed a comparison of the data on levels of observation provided by the PSNI for the 2020 Inspection Report and for this Follow-Up Review. This indicated that, since this recommendation was made, there had been an increase in the proportion of detainees placed on Level 1 and a reduction in those placed on Level 2. This suggested that more appropriate decisions were being made as to which level of observation to place the detainee on.

Table 2: Level of observation in custody recorded by the PSNI.

Level of observation	Description of observations	Proportion of detainees on each level	
		2018-19	2023-24
Level 1 **general observation**	Checked at least every hour	**30%**	**60%**
Level 2 **intermittent observation**	Visited and roused at least every 30 minutes	**43%**	**23%**
Level 3 **constant observation**	Constantly observed using closed-circuit television (CCTV) in addition to physical checks at least every 30 minutes	**26%**	**13%**
Level 4 **close proximity**	Detainee physically supervised in close proximity	**0.4%**	**0.7%**

Photograph 15

Close proximity observation cell door, Antrim Custody Suite

Photograph 16

Close proximity observation cell door, Musgrave Custody Suite

The actions taken by the PSNI to reinforce the quality of decisions around risk assessment and decision-making appeared to have resulted in variances in the overall use of the differences in levels of observation, which is a positive finding. There was also evidence from custody staff and in custody records of the greater use in the directions relating to, and practice of, rousing. However, there were still improvements needed in the quality of risk assessment and case planning and in recording the rationale for decisions made, as well as the way checks were conducted and recorded. There continued to be a need for this to be a long-term focus within the delivery of custody services.

Inspectors therefore assessed this recommendation as **partially achieved**.

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).
Status: Partially achieved.

Organisational response

The standards of cleaning required for custody suites are agreed with Sodexo who hold the contract for this area of business. Standing orders for the suites have specific guidance on cleaning and includes auditable returns which are held by the individual suites. Compliance is ensured by the custody policy team who conduct unannounced visits to the suites which includes the checking of cleaning records.

The PSNI assessed this recommendation as achieved.

Inspectors' assessment

Detainee areas in the custody suites visited were mostly cleaned to a good standard and there were regular refurbishment schedules. However, during their visits Inspectors identified areas that required attention from contracted cleaning staff.

Compared with the findings from the last Inspection, health care rooms were maintained to a good standard.

The standards for cleaning of clinical and non-clinical areas of Police Custody were available. Evidence of Custody Policy Branch quarterly audits however did not include an assessment of cleanliness and there was limited evidence of any unannounced visiting arrangement to observe the environment.

Evidence of a number of cleaning audits relating to one custody suite, carried out by the contracted cleaning agency, were submitted to Inspectors following the on-site visits. There did not appear to be sufficient clarity about who was responsible for the oversight of cleaning standards or auditing across all custody suites.

Inspectors assessed this recommendation as **partially achieved**.

Photograph 17

Detainee shower,
Dungannon Custody Suite

Photograph 18

Cell interior,
Antrim Custody Suite

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).
Status: Not achieved.

Organisational response

Medical Training Branch have confirmed that they teach the importance of updating and maintaining first aid equipment during training for custody staff. This is included in the standing orders which also includes audits which are completed following each check and retained in the custody suite. Compliance is ensured by the custody policy team who conduct unannounced visits to the suites which includes the checking of first aid equipment records.

The PSNI assessed this recommendation as achieved.

Inspectors' assessment

Inspectors observed all the necessary health care equipment was available in the custody suites visited.

A review of records in three custody suites indicated that all equipment was appropriate, ready for use, and had been regularly checked and maintained. However, this could not be evidenced across all suites.

The Quarterly Custody Suite Inspection record indicated that reviews by Custody Policy Branch had been completed in June 2024. However, this system had not identified when health care equipment had not been checked.

Inspectors observed emergency health care equipment had not been routinely checked and escalated this safety concern to the PSNI during the fieldwork element of this Follow-Up Review. Assurances were provided this would be addressed.

Inspectors assessed this recommendation as **not achieved**.

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).
Status: Not achieved.

Organisational response

CNPs employed by the Belfast HSCT working in Musgrave, Antrim and Waterside Custody Suites have full access to the medical records of people detained in those custody suites. The PSNI provided broadband to medical rooms which allows the Belfast HSCT to connect their equipment directly to the NIECR or encompass/EpicCare.[38]

During the financial year 01/04/23 – 31/03/24, there were 25,395 detentions in PSNI custody. Waterside Custody Suite opened in late November 2023 therefore during that financial year 65% of people detained in custody had access to the nurse-led service.

38 *EpicCare is a web-based portal that provides read only access to encompass. It grants access to clinical information documented in encompass and allows General Practitioners (and other health professionals) to access information about their patients.*

However, the subsequent closure of Coleraine and Strand Road Custody Suites effectively means that 76% of people detained in PSNI custody suites now have access to the nurse-led service and the improvements which accompany this service. This partially addresses this recommendation.

The PSNI Information and Communications Services Branch in liaison with Health and Social Care, Business Services Organisation, has trialled a number of solutions, including a common terminal linked to the NIECR, using a cryptokey which facilitated access to NIECR in each medical room.

However, FMOs did not utilise this option. Those common terminals were removed during the remodelling of medical rooms to an HSCT specification. Most recently a mobile tablet solution to the NIECR was trialled. At this point in time FMOs in Lurgan, Banbridge, Dungannon and Strabane Custody Suites do not have access to the NIECR.

The PSNI assessed this recommendation as not achieved.

Inspectors' assessment

In the nurse-led custody suites nurses had access to detainees' medical histories and currently prescribed medicines through NIECR and *EpicCare*. Policies and procedures were in place to ensure clinical records were completed, stored and retained in line with professional standards and legal requirements. Clinical records were observed to be maintained and stored in accordance with the Belfast HSCT policy and procedure and were subject to audit to ensure compliance.

Despite several attempts by Justice Healthcare Branch to provide FMOs with access to NIECR, FMOs were unable to access this system. FMOs were relying on the detainee being able to tell them what medicines they were currently prescribed. Access to the detainee's medical history is important in preventing prescribing errors and consequent risk to detainees.

In FMO-led services, policies and procedures had not been developed and implemented to ensure clinical records were completed, stored and retained in line with professional standards and legal requirements. There was no evidence that clinical records were subject to audit.

The PACE 15 and 15/1 medical forms were found to be completed clearly. However, practice was inconsistent regarding the storage and retention of FMO (blue) copies of PACE 15 and 15/1 forms. These records must be stored securely in line with professional standards and legal requirements. The white copies were shared with PSNI for uploading onto the Niche™ Records Management System.

Inspectors assessed this recommendation as **not achieved**.

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).**

Status: Not achieved.

Organisational response

Custody Policy Branch have produced updated standing orders in which there is clear guidance in relation to the management of medicines. This is in line with national guidelines issued through APP.

The Belfast HSCT appointed a pharmacist to work with CNPs as part of the pathfinder, which is normal Trust practice. This includes the acquisition of controlled drugs licenses, and the introduction of Patient Group Directions for the CNP's to dispense a number of medications. In addition, the development of the Homely Remedies policy facilitates the CNP's administration of non-prescription medicines available over the counter in community pharmacies, used for the short-term management of minor, self-limiting conditions.

Currently however, there is no pharmacist in post and this is with Business Services Organisation for recruitment. Seven members of nursing staff have successfully undertaken the non-medical prescribing course and are currently qualified non-medical prescribers; additionally a further three members of nursing staff are about to embark on this course in September 2024.

Reduction in the amount of medication carried by PSNI has been safely managed by the Belfast HSCT, as the CNPs check the NIECR or encompass/EPicCare to ascertain prescribed medications. Where a medication is not available and there is a need for a detainee to access medication, not covered by a Patient Group Directions, this medication is sourced from the detainee's home supply.

FMOs are independently engaged for the delivery of service, there is no clinical lead to implement any policy or procedure. FMOs are regularly in contact with Justice Healthcare Branch and any information regarding best practice is disseminated. FMOs have adopted prescribing practices of the Belfast HSCT and each FMO has access to their own individual supply, for which they are responsible.

The PSNI assessed this recommendation as partially achieved.

Inspectors' assessment

In the nurse-led custody suites, Belfast HSCT policies and procedures for the management of medicines were in place. Daily checks were completed to ensure that medicines were in date and stored securely at the appropriate temperature. Medicines held on-site included those for Patient Group Directions, emergency medicines, home remedies and Patient's Own Drugs. These medicines were managed by nursing staff only.

In accordance with the Human Medicine Regulations 2012, FMOs can hold stock of prescription only medicines to supply or administer directly to patients. These medicines are the property of the individual FMO and must be stored securely to prevent unauthorised access.

Medicines belonging to the FMOs were not held on-site in Musgrave Custody Suite and Inspectors were advised that a similar practice existed in Antrim and Waterside Custody Suites. Therefore, Inspectors were assured that FMOs had access to their individual supply of medicines only.

In the FMO-led custody suites, a generic policy was available for the management of medicines. It did not provide detailed guidance 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.

In Lurgan and Banbridge Custody Suites, custody staff advised that each FMO brought their own individual supply of medicines when they attended the custody suite. Custody staff did not have access to medicine cupboards and they were observed to be locked during the Follow-Up Review on-site visits.

However, supplies of NovoRapid insulin (a prescription only medicine) and Rapilose glucose gel were available in the medicine refrigerator in both custody suites. If a FMO chooses to store their individual supply of NovoRapid in the custody suite it must be stored securely and only they should have access. The temperature of the medicines' refrigerator was not monitored and some NovoRapid was out of date. Out of date medicines were segregated for disposal and systems were put in place to ensure the temperature of the medicines refrigerator was monitored following feedback given to the PSNI by Inspectors after the on-site visits.

In Dungannon Custody Suite, FMOs were able to access a shared supply of medicines. The medicine cupboards were locked, however, custody staff were able to provide access. Neither of these findings are in accordance with legislative requirements. The cupboards contained several medicines, including a number of out-of-date medicines.

The refrigerator was not being used to store medicines, it contained samples for medical testing only. The temperature of the refrigerator was not monitored.

The retention of out-of-date medicines, shared supplies of stock medicines and the need to monitor refrigerator temperatures was escalated by Inspectors to the PSNI for immediate action.

Although improvements were noted since the last inspection, Inspectors assessed this recommendation as **not achieved**.

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.)
Status: Not achieved.

Organisational response

Custody Policy as well as Custody Inspectors perform monthly audits of dip-sampled custody records. Pre-release risk assessment reviews form part of the audit. This, in turn, forms part of the performance framework for custody. Where non-compliance is identified, this is addressed with the officer.

The PSNI assessed this recommendation as achieved.

Inspectors' assessment

The PSNI advised that the first part of the action plan in relation to this recommendation was to circulate a newsletter to all custody staff in May 2020 which reinforced guidance, contained in the College of Policing *Detention and Custody* APP module, on pre-release risk assessments. Inspectors were not provided with a copy of the action plan developed in relation to this recommendation, but it was closed on the PSNI's recommendation overview system in July 2021. Audits of pre-release risk assessments were undertaken by Custody Inspectors and Custody Policy Branch in conjunction with audits undertaken on care planning and risk assessment (as outlined in Operational Recommendation 2). These had identified the need for more detail in pre-release risk assessments and this had also been identified as a topic for inclusion on the agenda of the next Continuing Professional Development day. It was unclear in some of the audits what follow-up actions or response was required from the Custody Officer.

In the custody records reviewed by Inspectors there continued to be a lack of detail in many of the pre-release risk assessments and Inspectors assessed that in around half the cases reviewed, all the identified risks had not been sufficiently considered and addressed. Although a smaller sample of cases were considered in this Follow-Up Review than for the 2020 Inspection Report, this figure was consistent with the previous findings.[39]

39 The 2020 Inspection Report states at paragraph 6.2, page 82 that '*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.*' See *CJI, Police Custody, The Detention of persons in Police Custody in Northern Ireland, September 2020,* available at **Police Custody: The detention of persons in police custody in Northern Ireland - CJI NI**

In many cases the risk was a summary of those recorded in the initial risk assessment and often the actions related solely to a referral sheet having been provided for drug, alcohol or mental health issues. In some cases, there was a note that the detainee had been offered the opportunity to see, or had seen, the HCP prior to release but this appeared to be more likely in suites where there was an embedded nurse-led service. In some cases where there was evidence of potential risks to the detainee or to others (for example, in domestic abuse cases where the detainee was returning to their current address) there was insufficient detail as to what actions had been taken to mitigate these. Positively, there appeared to be better recording as to who the detainee had been released into the care of or that they had been transported home by LPT Officers.

In October 2024 the PSNI announced to users that a planned update of Niche™ would take place in early November. This included an additional question as part of the pre-release risk assessment, relating to previously identified risks noted in the initial risk assessment or while in custody. The question required the Custody Sergeant to confirm whether they had considered all the risks identified in the initial risk assessment or while in custody and record details of advice given or arrangements made.

Similarly to Operational Recommendation 2 this is an area that the PSNI will need a continued focus on and an improvement in the quality of these risk assessments. This area required ongoing monitoring and feedback over the longer-term.

Inspectors assessed this recommendation as **not achieved**.

AREA FOR IMPROVEMENT 1
Further examination of the reasons for arrest and detention in custody of the Irish Travellers and people of Black ethnicities would be beneficial to see if any improvements in practice can be identified (paragraph 1.19).
Status: Not achieved.

Organisational response
A review of arrests and detention was carried out with no evidence that any arrest or detention was not necessary and proportionate. No improvements in practice were identified as required.

The PSNI assessed this Area for Improvement as achieved.

Inspectors' assessment

Inspectors were advised that the PSNI had undertaken a dip sample of over 10% of the custody records for 2018-19 referred to in the CJI 2020 report relating to Irish Travellers (737 detainees) and those from Black ethnicities (278 detainees) and occurrences linked to those individuals. The PSNI concluded that there was nothing to suggest that these arrests were not justified or proportionate and this recommendation had been closed on the PSNI's overview system. Inspectors were informed that the majority of the reasons for these arrests were as a result of police being called to an ongoing incident, such as a disturbance or a domestic incident. No further improvements in practice could be identified and the PSNI concluded that as there was no statistical significance to the differences, this piece of work would be a one-off. The PSNI were, however, unable to provide Inspectors with any documentary evidence to confirm the findings or outcomes of this work.

Data provided to CJI for the purposes of this Follow-Up Review showed that the proportion of Irish Travellers in the custody population had remained consistent since the 2020 Inspection Report (2.9% for 2023-24 (746 detainees out of a total of 25,515 detainees) and 2.8% for 2018-19 (737 detainees out of a total of 26,160). Similarly, the figures for detainees from Black ethnicities was 1.8% for 2023-24 (466 detainees) an increase from 1.1% (278 detainees) in 2018-19. These groups continued to be over-represented compared to the proportion in the population of Northern Ireland in the latest Census.[40]

Subsequent to CJI's 2020 Inspection Report, the NIPB *Human Rights 5 Year Review*[41] also noted concerns about the over-representation of Irish Travellers in contact with the PSNI in relation to stop and search powers. The report stated, '*A second issue that needs to be explored is why the figures for the numbers of Irish Travellers are so high*.'[42] The report compared statistical data published which suggested nearly 16% of the Irish Traveller population were subject to stop and search powers each year.

The report also noted that at a PSNI Service Accountability Panel meeting, in September 2023, it was agreed that an analysis of stop and search encounters involving members of the Irish Traveller community would be carried out. The analysis report was discussed at the Service Accountability Panel in November 2023. The NIPB therefore recommended that '*the report, 'An Analysis of Incidents of Stop Searches Conducted on Members of the Irish Traveller Community between 1st July 2022 and 30th June 2023' should be published and academic experts and any other relevant stakeholders on stop and search should be invited to comment*.' The report also noted that '*Given what is known about disproportionality in relation to community background, comparisons between those with Protestant backgrounds and these minority groups is likely to be even starker*.'

40 Census 2021 main statistics for Northern Ireland (phase 1) published by the Northern Ireland Statistics and Research Agency reports that 0.14% of the population were from a Traveller background and 0.58% of the population were from a Black ethnic group (Black African, Black Caribbean and Black Other). See **https://www.nisra.gov.uk/publications/census-2021-main-statistics-ethnicity-tables**.

41 *Northern Ireland Policing Board, Human Rights 5 Year Review, June 2024* available at **https://www.nipolicingboard.org.uk/files/nipolicingboard/2024-07/Human%20Rights%205%20Year%20Review%20-%20Final.pdf.**

42 The NIPB report quoted that 'A degree of undercounting may exist for the Irish Traveller category as some Irish Travellers are likely to be categorised as White.' Table 7, note (1) *Use of Stop and Search Powers by Police in Northern Ireland, October 2022 to September 2023, Northern Ireland Statistics Agency, 22 November 2023.*

Inspectors were therefore disappointed, considering the ongoing scrutiny and discussions between the PSNI and oversight bodies, that there had not been a longer-term approach to monitoring the circumstances that led to the detention of individuals who were held in police custody from Irish Traveller or Black ethnicity backgrounds. Monitoring was an ongoing requirement, with reviews undertaken if disproportionate outcomes were identified across different groups or categories of person so that organisations could take appropriate actions to address any issues identified. The NIPB Human Rights Advisor's concluding comments in the *5 Year Human Rights Review* in relation to stop and search were equally relevant to the issue of arrest and detention: '*therefore, if the evidence is that a disproportionate number of people from one religion, national or social origin, national minority political group were subject to disproportionate action by a police service this would be unlawful - unless that difference can be objectively justified, and this justification is a legitimate one. It is the responsibility of the police service to investigate this disproportionality and to justify it, if the service is it to avoid the finding of a violation*.'

In October 2024 the PSNI published a consultation on a Race and Ethnicity Action Plan for 2025-27.[43] There were a number of areas under Workstream 2 - Professionalism, Powers and Policies which are of relevance to this area for improvement as outlined Table 3.[44]

Table 3: Extract from the PSNI's Race and Ethnicity Action Plan 2025-27: Workstream 2 - Professionalism, Powers and Policies

A Police Service that is fair, respectful and proportionate in its actions towards people from ethnic minority backgrounds.	
What we will do	***How we will do it***
• Embedding the principles of the professionalism and Code of Ethics. • Eliminate any racial bias, stereotyping, profiling or discrimination in our actions.	• Through analysis, supervision and scrutiny of police powers at service and individual levels, identify and take actions to eliminate any identified racial disparities.
• Appropriate use of powers - Reducing the risk of criminalising people from ethnic minority communities by ensuring that they benefit from appropriate response, early action, prevention and diversion.	• Treating everyone from ethnic minority communities who have contact with the police fairly and with respect.
• Strengthen workforce knowledge and oversight of the use and impact of police powers.	• Using police powers - such stop and search and traffic stops - proportionately and only when lawful and necessary. • Reducing racial disparities in the use of police powers and criminal justice outcomes.

43 *PSNI, Race and Ethnicity Action Plan 2025 - 2027: Equality in Action - Delivering Effective and Trusted Policing for Ethnic Minority Communities, Officers and Staff: Draft for Consultation Purposes, October 2024,* available at **https://www.psni.police.uk/about-us/our-policies-and-procedures/race-and-ethnicity-action-plan-2025-2027-consultation**.

44 This table relates to selected aims and objectives only - the full version of the report can be accessed on the PSNI's website as in the previous footnote.

Inspectors hope that the PSNI's ambitions, as included in the Race and Ethnicity Action Plan, provide a further opportunity to examine the data relating to the arrest and detention of people in police custody from Irish Traveller, Black ethnicities and other ethnic minorities and identify any improvements in practice.

Inspectors assessed this Area for Improvement as **not achieved**.

AREA FOR IMPROVEMENT 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).
Status: Partially achieved.

Organisational response

Custody Policy, as well as Custody Inspectors, perform monthly audits of dip-sampled custody records. Sleeping reviews form part of the audit. This forms part of the performance framework for custody. Where non-compliance is identified, this is addressed with the officer.

The PSNI assessed this area for improvement as achieved.

Inspectors' assessment

The PSNI provided evidence from their own audits (as described in relation to care plans for Operational Recommendation 2), undertaken by Custody Inspectors and Custody Policy Branch, in relation to this Area for Improvement. Sleeping reviews formed part of the audits of custody records, under the performance framework for custody. Where non-compliance was identified, the PSNI advised that it was addressed with individual Police Officers.

Inspectors were unable to ascertain the focus of the audits. It was unclear if the audit looked at whether a record was made that the detainee had been informed about the decision made by the Reviewing Inspector[45] or whether it was a qualitative assessment of the reasonableness of this decision in the circumstances. Inspectors did see notes that an email had been sent to the Custody Sergeant in some cases where a sleeping review took place and therefore assumed that some feedback was provided in those cases. Although, Inspectors welcome the inclusion of sleeping reviews in the monthly audits this information did not appear to be collated and used to inform wider organisational learning or training.

45 PACE Code C requires that the detainee is informed of the Reviewing Inspector's decision to continue their detention as soon as is practicable after waking.

In the custody records Inspectors reviewed there continued to be some evidence of a record that the detainee was asleep either closely after or before a period where the detainee was recorded as awake. Inspectors would therefore encourage the PSNI to continue to keep this issue under review and provide feedback to Duty Inspectors where appropriate. It would also be beneficial to consider how training for Inspectors undertaking PACE reviews and custody staff could incorporate the learning from these audits.

Inspectors therefore assess this Area for Improvement as **partially achieved.**

AREA FOR IMPROVEMENT 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).**
Status: Achieved.

Organisational response

All current cells, dedicated holding cells, waiting areas and dedicated exercise yards have video and audio recording capability. In cell recording commences when the cell door is opened and ends when the door is closed. This is augmented by the presence of video and audio recording in the corridors outside of cells and in circulation areas. Microphones operate effectively to approximately 7 metres. Only legal and medical consultation rooms are exempted from cameras and microphones. Improvements to video and audio recording technology is reviewed with the passage of time and during maintenance Inspections/refurbishment works. In addition, the PSNI have an ongoing programme to replace older, analogue, camera equipment with digital technology.

The PSNI assessed this Area for Improvement as achieved.

Inspectors' assessment

During this Follow-Up Review Inspectors did not review CCTV as part of an assessment of custody cases where force had been used, as was undertaken in the original Inspection methodology.

However, Inspectors observed that Dungannon Custody Suite had been refurbished since the 2020 Inspection and that CCTV with audio signage was present (see photographs 19 and 20 for examples of this signage.) The new build at Waterside Custody Suite also had extensive coverage throughout the custody suite. Inspectors noted that the in-cell recording commences once the cell door is opened and when the cell intercom system

is activated, which is in accordance with the College of Policing *Detention and Custody Authorised Professional Practice* module.[46]

Inspectors assessed this Area for Improvement as **achieved**.

Photograph 19

CCTV with audio signage in cell, Waterside Custody Suite

Photograph 20

CCTV with audio signage in cell, Musgrave Custody Suite

AREA FOR IMPROVEMENT 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).

Status: Achieved.

Organisational response

A process has been developed in partnership with the HSCTs which means all children on the Child Protection Register (CPR) are flagged on the Police NICHE system. This information is available to custody staff and is accessed as part of the risk assessment for all detainees as part of the assessment involves checking flags linked to the detainee.

The PSNI assessed this Area for Improvement as achieved.

46 *College of Policing, CCTV, Authorised Professional Practice: Detention and Custody, October 2013 (updated October 2024),* available at https://www.college.police.uk/app/detention-and-custody/cctv.

Inspectors' assessment

In the cases reviewed by Inspectors it was evident that there was a flag on the Niche™ record for children who had been placed on the CPR. The flag included the date on which the child had been placed on the Register and the categories (suspected or confirmed physical, sexual or emotional abuse or neglect). A document from the relevant HSCT was available which provided limited details of the Case Conference at which the chid had been placed on the Register, including details of the child, the date of the Conference, attendees and the suspected or confirmed categories.

The parents of guardians of a child on the CPR also had a flag on their record to indicate that they were the 'parent of [named child]' who was on the CPR under the specified categories.

CJI's Pilot Joint Inspection of Child Protection Arrangements in the Southern HSCT noted that while a flag on the police system to alert Police Officers if a child was on the CPR was positive, it was not accompanied by information about the nature of the risk or who posed a threat of harm to the child.[47]

The flag still did not give an indication as to which individual or individuals posed the risk to child: whether it was the parent or guardian or another individual within or outside the family. This therefore did not assist Custody Sergeants in making decisions about the appropriateness of the parent or guardian for the purposes of performing the role of Appropriate Adult, as provided for under PACE Code C. This information was not evident from the Case Conference document.

Custody Sergeants and CDOs confirmed that it was not evident to them from the record who posed the risk to the child. In cases where the child was residing in a Children's Home, they were able to draw on information provided by staff about the child's circumstances (although as these children are in the care of the relevant HSCT they are removed from the CPR). For those living at home however, where it was difficult or impossible to be able to access this information from an out-of-hours Social Worker, staff had to draw on previous knowledge of the child within the PSNI or other information available on the Niche™ Records Management System.

PACE Code C Note for Guidance 1B[48] placed a responsibility on the Custody Sergeant to make decisions about the suitability of a person performing the role of an Appropriate Adult. It was difficult for Custody Sergeants to fully explore the suitability of a parent whose child is on the CPR if they were not aware of relevant pertinent information, particularly as to whether the parent is the person who posed a risk to the child. Inspectors would therefore encourage the PSNI to explore what further information can be provided (acknowledging that sensitive information should be protected where possible) to enable Custody Sergeants to make fully informed decisions. This will be further reviewed in future inspections of police custody.

47 *CJI, A Pilot Joint Inspection of Child Protection Arrangements in the Southern Health and Social Care Trust Area, Summary report, June 2023,* available at **First joint inspection of Child Protection Arrangements - CJI NI**

48 See DoJ, *PACE Code C: Detention, treatment and questioning of persons by police officers, June 2015,* available at **https://www.justice-ni.gov.uk/publications/pace-code-c-detention-treatment-and-questioning-persons-by-police-officers**.

Inspectors assessed this Area for Improvement as **achieved**.

AREA FOR IMPROVEMENT 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.)
Status: Partially achieved.

Organisational response

HCPs deliver a lesson on all initial custody courses for Sergeants and CDOs. All custody staff also receive enhanced first aid training. There are a number of mandatory learning packages that staff must complete such as Acute Behavioural Disturbance.

With the provision of 24/7 Healthcare in Musgrave, Antrim and Waterside Custody Suites, custody staff can seek immediate advice if they have any concerns about a detainee which has improved the ability to effectively meet the needs of detainees.

The PSNI assessed this Area for Improvement as achieved.

Inspectors' assessment

It was unclear what the training expectations were for custody staff in relation to meeting the health care needs of detainees. The PSNI should undertake a training needs analysis to establish what the training requirements are for custody staff in respect of health care needs.

The previous report issued in September 2020 stated that custody staff received resuscitation training every year and first aid every three years. However, Inspectors were not provided with a training matrix to ensure that these timescales had been complied with.

Following the Follow-Up Review feedback to PSNI, records relating to Defibrillation and Oxygen training only, were forwarded to Inspectors. The review of these records evidenced satisfactory compliance with training in these two areas.

Custody staff informed Inspectors during fieldwork that they felt they were not equipped with the appropriate skills to effectively support patients who present with mental health distress and would benefit from additional mental health awareness training.

It was expected that custody staff administer medication, however the majority had not been trained in medicines administration. The 2020 Inspection Report noted that custody staff had not received training on dealing with blood or body fluids. Inspectors were not assured in this Follow-Up Review that this training need had been considered or addressed.

Training was also discussed during the meeting with the Justice Healthcare Branch who advised Inspectors that further eLearning packages and Mental Health First Aid Training were being considered for custody staff.

Inspectors assessed this Area for Improvement as **partially achieved**.

AREA FOR IMPROVEMENT 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).
Status: Not achieved.

Organisational response

Options in relation to this recommendation were explored including a proposed pilot scheme. A business case was submitted and a travel warrant card produced as well as an account opened with Translink. Due to budgetary pressures, however, the scheme (including the pilot) could not be funded.

The PSNI assessed this Area for Improvement as not achieved.

Inspectors' assessment

Inspectors were provided with a copy of the business case created for this recommendation. The figures within it related to one custody suite and clearly indicated a significant value for money rationale for implementing a travel scheme for detainees, rather than the existing position of LPT Officers transporting them home. However, as funding was not available for a pilot scheme it was not possible to explore options further.

In the custody records assessed, Inspectors sought to establish how detainees made their way home after release. In some cases, custody staff appropriately made efforts to ensure vulnerable people were transported home or into the care of family or friends by police or that they were collected by a trusted individual. This included both those flagged as vulnerable through a risk assessment process but also those who may not be considered vulnerable in all circumstances but could be in the context of the release (for example, female detainees released late at night). However, in many cases LPT Teams were requested to transport detainees to their home who were not vulnerable or whose only challenge was the distance to home and lack of funds to travel there. Detainees were sometimes recorded as being asked to sit in empty waiting rooms next to the Enquiry Office while waiting for Police Officers to get free time to transport them, which could take several hours. Some custody staff said that they had advised detainees to show Translink staff their bail sheet to avail of free travel; an alternative solution that neither they nor Inspectors considered appropriate to protect the dignity of detainees.

Universally those spoken to during fieldwork were in favour of a travel scheme and believed that both LPTs and detainees would be better served by its introduction. Inspectors appreciated the additional financial cost of such a scheme but still believed it offered clear value for money over the current arrangements. Inspectors urged the PSNI to look again at the business case in light of PSNI modernisation and current pressures on Officer resources to consider how a pilot scheme could be funded that would enable a full analysis of the options to be conducted. While acknowledging the work undertaken to consider options for a travel scheme in line with the recommendation, this was not progressed beyond the development of a business case due to funding pressures.

Inspectors assessed this Area for Improvement as **not achieved.**

CHAPTER 3: CONCLUSION

The fieldwork for this Follow-Up Review, including the visits to custody suites by Inspectors from CJI and RQIA and the NIPB's Human Rights Advisor and staff and the feedback sought from detainees and their advocates has supported collaborative monitoring and oversight. It has also contributed to CJI and RQIA responsibilities as UK NPM members in seeking to prevent torture and ill-treatment in places of detention. Overall, as in previous Inspections, findings in relation to the treatment of detainees held in police custody in Northern Ireland were positive. Detainees, in the main, felt safe, well treated and that their needs in custody were addressed.

Although the buildings in the custody estate varied in age and size they were well maintained and there was a regular schedule of refurbishments. Storage and cleanliness were an issue in some suites, but in the majority of cases the cells, facilities and communal areas were clean and risks to detainees and staff appeared mainly to be mitigated appropriately. Detainees reported being able to contact or receive support from family or friends, solicitors, social workers and interpreters as required. In most cases detainees were aware of what was happening with their case and when they would leave custody. Inspectors witnessed respectful interactions between staff and detainees and some positive feedback was received about the caring approach of some staff.

There was a 'mixed economy' in how technology was being used to support first appearances and transport arrangements for those being remanded in custody. This needs to be resolved as does the use of Police Officers to transport people released from police custody.

The 2020 Police Custody Inspection Report made five Strategic and seven Operational Recommendations to the PSNI, as well as one Strategic Recommendation to the DoJ. It also identified six Areas for Improvement for the PSNI to address.

Of the six Strategic Recommendations Inspectors assessed that one was achieved, four were partially achieved and one was not achieved. Of the seven Operational Recommendations Inspectors assessed that none were achieved, two were partially achieved and five were not achieved. Finally, Inspectors assessed that two of the six Areas for Improvement had been achieved, with two partially achieved and two not achieved.

Overall Inspectors assessed that 11 of the 19 Recommendations and Areas for Improvement had been achieved or partially achieved with the remainder not achieved. This was disappointing and at odds with the DoJ and PSNI's own assessment of progress where 16 of the Recommendations and Areas for Improvement (one addressed to the DoJ and 15 to the PSNI) had been assessed as achieved or partially achieved and three as not having been achieved.

The pace of legislative reform to address the alternatives to custody for children is disappointing, this is a long-standing issue and it could be some years before much needed change is implemented.

In part, the assessment of progress is impacted by the time taken to fully rollout the nurse-led model to all custody suites and a lack of assurance around the existing monitoring and governance arrangements of FMO-led suites. The rollout of the nurse-led model should be expedited at pace, given the potential risk for detainees and staff in custody suites and wider public safety where health care is only provided by the FMO service.

It was also evident that work had been completed by the PSNI in some areas at the time of the previous Inspection Report but that no ongoing monitoring had taken place, for example the examination of the over representation of Irish Travellers and black people in detention.

Inspectors would encourage the PSNI, with its partners, to continue to focus on completing implementation of the recommendations which have not yet been achieved. CJI and RQIA, will continue to undertake regular Inspections of police custody, as bodies of the UK NPM, and therefore outstanding issues will be returned to in a future full Inspection. Some areas, such as the approach to risk assessment and care planning, are likely to continue to need a long-term focus and oversight in order to ensure consistency and quality.

APPENDIX 1: NORTHERN IRELAND POLICING BOARD MONITORING FRAMEWORK

HUMAN RIGHTS AND POLICE CUSTODY

Everyone has the right to liberty and security of their person. No one shall be subjected to arbitrary arrest or detention.[49]

Deprivation of liberty of persons shall be as limited as possible and conducted with regard to the dignity, vulnerability and personal needs of each detainee.[50]

Arrest and detention must be carried out in accordance with the law.[51]

All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person.[52]

Any form of detention or imprisonment and all measures affecting the human rights of a person under any form of detention or imprisonment shall be ordered by, or be subject to, the effective control of a judicial or other authority.[53]

The unacknowledged detention of an individual is a breach of the right to liberty. Having assumed control over an individual, it is incumbent on the authorities to account for his/her whereabouts.[54]

All money, valuables, clothing and other property belonging to a detainee which he is not allowed to retain shall be placed in safe custody.[55]

Reasonable Suspicion

There must be a reasonable suspicion that an individual has committed a criminal offence (or reasonable suspicion that he or she has been involved in acts of terrorism) before an arrest or the use of general stop and search powers.[56]

Having a 'reasonable suspicion' presupposes the existence of facts or information which would satisfy an objective observer that the person concerned may have committed the offence.[57]

49 UDHR Articles 3 and 9, ICCPR Article 9(1); CERD Article 5(b); ECHR Article 5(1)).
50 European Code of Police Ethics, Article 54.
51 ECHR Article 5(1); UN Body of Principles, Principle 2.
52 PSNI Code of Ethics, Article 5.1, ICCPR Article 10; CRC Article 37(c); ECHR Article 3, UN Body of Principles, Principle 1; Police and Criminal Evidence (NI) Order 1989 Codes of Practice C-E; Bouyid v Belgium (2015).
53 UN Body of Principles, Principle 4.
54 Kurt v Turkey (1998).
55 PSNI Code of Ethics, Article 8.1, Mandela Rules, Rule 67.
56 PSNI Code of Ethics, Article 2.2, Fox, Campbell and Hartley v UK (1990); European Code of Police Ethics, Article 47.
57 Fox, Campbell and Hartley v UK (1990).

The honesty and good faith of the police officer's suspicion constitute indispensable elements of its reasonableness.[58]

Reasons

Everyone arrested should be informed, in a language s/he understands of the reasons for his/her arrest.[59] Simple, non-technical language should be used.

Notification should be at the time of arrest or as soon as practicable thereafter.[60]

Sufficient details should be given to enable the person arrested to know the basis upon which s/he is being held. This should include the facts alleged and the relevant criminal law.

Detained persons should be provided with information on and an explanation of their rights and how to avail themselves of their rights.[61]

The reasons for the arrest, the time of the arrest, the identity of the police officers concerned and the place of custody of the detained person should be recorded.[62]

Detained persons should be entitled to notify or to require the competent authority to notify members of their family or other appropriate persons of their choice of their arrest, detention or imprisonment.[63]

External Communication

Communication of a detained person with the outside world, in particular, his/her family and legal representative, should not be denied for more than a matter of days[64] and shall be allowed under supervision at regular intervals thereafter.[65]

Access to a Lawyer

Everybody should be informed of the right to be assisted by a lawyer upon arrest.[66]

Access to a lawyer is fundamental and should not be delayed.[67] However, access to a lawyer can be delayed where there is a proper basis for believing that there is a risk that such access will frustrate the arrest of other suspects[68] or where there are other exceptional circumstance – for instance for the preservation of life.[69]

58 Fox, Campbell and Hartley v UK (1990).
59 ICCPR Article 9(2); ECHR Article 5(2); UN Body of Principles, Principle 10.
60 Fox, Campbell and Hartley v UK (1990).
61 UN Body of Principles, Principle13; European Code of Police Ethics, Article 55.
62 Mandela Rules, Rule 7(1)) and such record should be communicated to the detained person or his counsel, if any (UN Body of Principles, Principle 12.
63 UN Body of Principles, Principle 16(1); European Code of Police Ethics, Article 57.
64 UN Body of Principles, Principle 15.
65 Mandela Rules, Rule 58; McVeigh, O'Neill and Evans v UK,(1981).
66 (UN Basic Principles on the Role of Lawyers, Principle 5.
67 UN Basic Principles on the Role of Lawyers, Principle 5; Murray v UK (1996), Magee v UK (2002).
68 Brennan v UK (2002).
69 Ibrahim v UK (2016).

Communications between a suspect and his/her lawyer should be confidential[70] and inadmissible as evidence unless they are concerned with a continuing or contemplated crime.[71]

The right of access to a lawyer must be effective – the right is to a private conversation for a reasonable time.

However, there is no right to access to a lawyer before a roadside breath test is administered;[72]

Questioning

No suspects should be subject to violence, threats or methods of interrogation which impair his/her capacity to make decisions or judgements.[73]

All suspects have the right to remain silent during questioning[74] but adverse inferences can be drawn from silence, so long as they are fair and legitimate;[75] however, appropriate weight must be given to the explanation given by the defendant for exercising his right to silence.[76]

Any force used during interrogation (e.g. slapping and kicking) is inhuman treatment and prohibited.[77]

The time and place of all interrogations should be recorded.[78]

Registers should be kept of all those in custody, which should be accessible to relatives and friends.[79]

Children and those who appear to be "mentally vulnerable" should have an appropriate adult to support them in the police station[80]. Consideration should also be given to providing support for older persons in the police station who may be more likely to have issues with memory recall and failing physical health.

70 S v Switzerland (1991).
71 UN Body of Principles, Principle 18(5).
72 Campbell v DPP (2002) EWCA 1314.
73 UN Body of Principles, Principle 21(2).
74 ICCPR, Article 14(3)(g); Article 40(2)(b)(iv); Funke v France (1993); Saunders v UK (1996).
75 Murray v UK (1996); Condron v UK (2000); Beckles v UK (2003).
76 Beckles v UK (2002).
77 Ribitsch v Austria (1995); Tomasi v France (1992); Bouyid v Belgium (2015).
78 UN HRC General Comment 20; UN Body of Principles, Principle 23(1).
79 UN HRC General Comment 20.
80 The Appropriate Adult has an important and positive role while supporting vulnerable people and juveniles in Custody, this includes ensuring that the detained person understands what is happening to him and why. The NI Appropriate Adult Scheme is available throughout NI.

The Right to be Brought Promptly before a Court

Everyone arrested for a criminal offence has the right to be brought promptly before a court.[81]

An assessment of 'promptness' has to be made in the light of the object and purpose of this requirement, which is to protect the individual against arbitrary interference by the state; the European Court of Human Rights has decided that ordinarily the period of detention before a person is brought before a court should not be longer than four days.[82]

The court before which a person is brought must have power to order release.[83] Alternatively a detained person may be brought before an officer authorised by law to exercise judicial power.[84] Such an officer must have some of the attributes of a judge: s/he must be independent, impartial and must consider the facts and have power to order release.[85]

Bail

The general presumption is that those awaiting trial should not be detained but released.[86]

Bail may be refused if it is necessary to prevent a person absconding, interfering with the course of justice or for the protection of others, but the reasons must be relevant and sufficient.[87] Bail may be conditional.[88]

Material relevant to the decision whether to grant bail should in principle be disclosed to the suspect, but may be edited to protect the identity of informants.[89]

DETENTION

Basic Provisions

Torture, inhuman and degrading treatment are prohibited absolutely.[90]

No justification or excuses, including state of war, threat of war, internal political instability or any other public emergency (such as combating organised terrorism and crime,[91] may be invoked to justify the prohibition on torture, inhuman and degrading treatment.[92]

81 ICCPR Article 9(3); ECHR Article 5(3); CRC Article 40(2) (b)(iii); UN Body of Principles, Principle 37; Brogan v UK (1998).
82 Tas v Turkey (2001).
83 Ireland v UK (1978).
84 ECHR Article 5(3).
85 Schiesser v Switzerland (1979).
86 ICCPR Article 9(3); ECHR Article 5(3); UN HRC General Comment 8; UN Body of Principles; Principle 39; Tokyo Rules, Rule 6; Wemhoff v Germany (1968).
87 Stogmuller v Austria (1969); Neumeister v Austria (1968); Tomasi v France (1992); Van Alphen v Netherlands, UN HRC Communication No.305/1988, HRC 1990 Report, Annex IX.M.
88 Wemhoff v Germany (1968).
89 Re Donaldson's Application for Bail [2003] NI 93.
90 PSNI Code of Ethics, Article 1.4, UDHR Article 5; ICCPR Article 7; CAT Article 2(1); CRC Article 37(a); ECHR Article 3; UN Body of Principles, Principle 6; UN Code of Conduct, Article 5; Chahal v UK(1996); A and Ors v Secretary of State for the Home Department, [2005] UKHL 71.
91 Selcuk and Askar v Turkey (1998).
92 CAT Article 2(2); UN Body of Principles, Principle 6; UN HRC General Comment 20.

The victim's conduct is irrelevant.[93]

Where an individual enters custody uninjured and is later found to have injuries, it is incumbent on the detaining authorities to explain how the injuries occurred or risk the drawing of an adverse inference.[94]

Individuals should also be given access to a lawyer and right to have their arrest communicated to a relative or friend.[95]

Conditions of Detention and Ill-treatment

Detained persons should be given the right to a medical examination on admission.[96] The full protection of the health of persons in custody should be ensured and medical attention provided when required and the particular sanitary needs of women and girls should be considered.[97]

Any unnecessary and deliberate force against those in detention is inhuman treatment;[98] deliberately striking a defendant and handcuffing him causing real injury is capable of amounting to inhuman treatment.[99]

Very special reasons are needed to justify solitary confinement, restrictions on wearing own clothes and eating own food for those awaiting trial (Ramirez Sanchez v France (2006)).

Instruments of restraint, such as handcuffs, chains, irons and strait-jackets, shall never be applied as a punishment.[100]

Allegations of ill-treatment, including all suspected cases of extra-legal, arbitrary and summary executions, must be properly, promptly and impartially investigated.[101]

Evidence obtained by ill-treatment must be excluded at trial.[102]

Other conditions in detention may also raise questions about compliance with ECHR Article 3 and the equivalent UN treaties. The detainee must not be detained in overcrowded conditions and must be provided with refreshments, opportunities for exercise, natural light and proper washing and toilet facilities etc.[103]

93 Chahal v UK (1996).
94 Ribitsch v Austria (1995).
95 PACE, Article 57, European Committee for the Prevention of Torture, three fundamental safeguards (2002).
96 UN Body of Principles, Principle 24.
97 PSNI Code of Ethics, Article 5.3, UN Code of Conduct, Article 6; UN Standard Minimum Rules for the Treatment of Prisoners, Rule 22; Bangkok rules (for women); Beijing Rules (for young people).
98 Ribitsch v Austria (1995).
99 Egmez v Cyprus (2002).
100 (UN Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules, Rule 47).
101 CAT Articles 12 and 13; UN Body of Principles, Principle 7; UN Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions; Assenov v Bulgaria (1998).
102 CAT Article 15; Austria v Italy (1963); A and Ors v Secretary of State for the Home Department, [2005] UKHL 71.
103 CPT, 2nd General Report,1992.

Those controlling places of detention, including police stations, must allow national and international independent inspectors and monitors (including the Policing Board's own Custody Visitors) to have unfettered access to all places of detention and to speak privately to those detained.[104]

CHILDREN

In all actions concerning children, the best interests of the child are the primary consideration.[105]

Actions by police officers dealing with children should be explained in a language that child understands[106] – in both written and verbal formats.

A child must be afforded such protection and care as is necessary for his or her well-being.[107] Children are particularly vulnerable to sexual exploitation and abuse and need extra protection. The Safeguarding Board for NI[108] has 27 members, from the statutory and voluntary sector, of which PSNI are a member, whose common purpose is to help safeguard and promote the welfare of children and young people in NI.

Protecting a child's privacy is of paramount importance.[109] No information that may lead to the identification of a juvenile offender should be published but the courts can allow publication in exceptional circumstances.[110] Records of juvenile offenders should be kept confidential and closed to third parties.[111]

Arrest, detention or imprisonment of a child should be used only as a measure of last resort and for the shortest appropriate period of time.[112]

No child should be interviewed without an appropriate adult present and in a manner that secures informed engagement from the children.

Detention pending trial should be limited to exceptional circumstances and whenever possible be avoided and replaced by alternative measures such as close supervision.[113]

While in custody, children should receive care, protection and all necessary individual assistance.[114]

104 Optional Protocol to the Convention Against Torture and the European Convention for the Prevention of Torture.
105 Article 53, Justice (NI) Act (CRC Article 3(1).
106 UNCRC art 13.
107 CRC, Article 3(2); Beijing Rules, Rule 5.
108 The Safeguarding Board Act (Northern Ireland) 2011 was passed in February 2011. It provided the legislative framework for the creation of a new regional Safeguarding Board for Northern Ireland (SBNI) and the establishment of five Safeguarding Panels to support the SBNI's work at a Health and Social Care Trust level.
109 ICCPR Article14(1); CRC Article 40(2); Beijing Rules, Rules 8 and 21.
110 The Criminal Justice (Children) (Northern Ireland) Order 1998) (Beijing Rules, Rule 8.2.
111 Beijing Rules, Rule 21.1.
112 CRC Article 37(b); Beijing Rules, Rule 13.1; UN Rules for the Protection of Juveniles Deprived of their Liberty, Rules 1 and 2.
113 Beijing Rules, Rule 13.2; UN Rules for the Protection of Juveniles Deprived of their Liberty, Rule 17.
114 Social, educational, vocational, psychological, medical Rules, Rule 13.5; UN Rules for the Protection of Juveniles Deprived of their Liberty, Rule 28.

A child's parents of guardian should be immediately notified of the apprehension of their child and a judge or other competent official or body should without delay consider the issue of release.[115]

Where there are no grounds for denial of bail, as outlined above, all efforts should be made engage with relevant statutory authorities and the child's legal guardian to ensure that safe accommodation in the community is found.[116]

Police officers who frequently or exclusively deal with juveniles or who are primarily engaged in the prevention of juvenile crime should be specially instructed and trained.[117] There should also be a presumption of diversion from the criminal justice system where-ever possible.[118]

Adaptations to the criminal justice system are needed where children are on trial.[119] Basic procedural safeguards should be guaranteed at all stages of any criminal proceedings.[120]

The procedure should take account of the child's age and the need to promote their rehabilitation.[121]

A child capable of forming his/her own views should have the opportunity to be heard and express those views freely in any judicial, administrative or other matter affecting him/her, either directly or through a representative or other appropriate body. The child's views should be given due weight in accordance with the age and maturity of the child and should be supported by an appropriate adult.[122]

Note: the national law in Northern Ireland largely reflects these international laws – see, for instance, the Police and Criminal Evidence Order 1989.

115 Beijing Rules, Rule 10.
116 The Criminal Justice (Children) (Northern Ireland) Order 1998.
117 UNCRC Art 4 (GC 5)) (Beijing Rules, Rule 12.1.
118 UNCRC (art 40 (3) (b).
119 T and V v UK (1999).
120 Beijing Rules, Rule 7.1.
121 ICCPR Article 14(4).
122 CRC, Article 12.

GLOSSARY

Bangkok Rules:
The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders

Beijing Rules:
The United Nations Standard Minimum Rules for the Administration of Juvenile Justice

Body of Principles:
The United Nations Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment

CAT:
The United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

CEDAW:
The United Nations Convention on the Elimination of All Forms of Discrimination against Women

CERD:
The United Nations International Convention on the Elimination of All Forms of Racial Discrimination

CPT:
The Council of Europe European Convention for the Prevention of Torture, Inhuman and Degrading Treatment or Punishment

CRC:
The United Nations Convention on the Rights of the Child

CRPD:
The United Nations Convention on the Rights of Persons with Disabilities

ECHR:
The European Convention on Human Rights

ECtHR:
The European Court of Human Rights

ICCPR:
The United Nations International Covenant on Civil and Political Rights

Mandela Rules:
The United Nations Standard Minimum Rules for the Treatment of Prisoners

PACE:
The Police and Criminal Evidence (Northern Ireland) Order 1989

Tokyo Rules:
The United Nations Standard Minimum Rules for Non-custodial Measures

UN:
United Nations

UN Body of Principles:
UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment

UN HRC:
United Nations Human Rights Committee (set up by the ICCPR)

UN Principles on the Use of Force:
United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials

UN Code of Conduct:
United Nations Code of Conduct for Law Enforcement Officials

UDHR:
The United Nations Universal Declaration of Human Rights

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