

Report on an announced inspection visit to police custody
suites and court cells in

the Cayman Islands

by HM Inspectorate of Prisons

8–16 January 2015

Glossary of terms

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England

Contents

Introduction	5
Report A. Inspection of police custody suites	7
Section 1. Background and key findings	7
Section 2. Strategy	11
Section 3. Treatment and conditions	13
Section 4. Individual rights	17
Section 5. Health care	19
Section 6. Summary of recommendations	21
Report B. Inspection of court cells	23
Section 7. Background and key findings	23
Section 8. Leadership, strategy and planning	25
Section 9. Treatment and conditions	27
Section 10. Individual rights	29
Section 11. Summary of recommendations	31
Appendices	33
Appendix I: Inspection team	33
Appendix II: Progress on recommendations from the last report: Police custody suites	35
Appendix III: Progress on recommendations from the last report: Court cells	39

Introduction

The Cayman Islands are a self-governing British Overseas Territory comprising three islands in the Caribbean. HM Inspectorate of Prisons had carried out a previous inspection of custodial facilities in 2012, at the invitation of the Governor of the islands (who has responsibility for internal security). The focus of the present inspection was the Royal Cayman Island Police Service (RCIPS) custody suites at George Town, Bodden Town and the police marine unit base, as well as the court cells in George Town. We were unable to visit the two police cells on Cayman Brac and one on Little Cayman; we were told that they are little used and in good condition.

As previously, we used our usual inspection methodology and criteria but interpreted our Expectations in the light of the specific context, taking account of potential cultural and contextual differences between the Cayman Islands and the UK. The structure of the report follows that of our regular inspections in the UK: covering strategy, treatment and conditions, individual rights and health care.

There had been a number of improvements in the way in which custody processes were structured and carried out since the previous inspection. Practice guidance documents had been drawn up for the police service, incorporating learning from other jurisdictions. Staff had been trained in custody duties (both police and court custody), and there was better recording of, and learning from, incidents such as the use of force.

The cells at West Bay, which were not fit for habitation, had been decommissioned. Detainees were told their rights, and there was no evidence of over-long stays in police custody.

Nevertheless, there was still considerable room for improvement; in particular, there were two grave areas of concern. The first of these was the physical facilities. The cells at George Town police station, which we described in 2012 as 'barely fit for human habitation', had not changed. A new custody suite was almost complete, but its opening had been delayed for seven months and there was still no date set. Further, circumstances described in this report had made the cells at George Town, which were normally used for the detention of women and children, unavailable for use since the previous inspection, leading to wholly unsatisfactory conditions for them. The custody suite at the courthouse also remained unchanged and inadequate.

Secondly, custody practice across the board suffered from fragility and inconsistency because of the lack of clear formal policies and standards. This applied both to police working practices (with unclear operating standards resulting in inconsistent treatment) and also to coordination and cooperation between partner agencies. This cooperation worked well enough in an informal way for routine matters (and such day-to-day cooperation had improved in court custody), but was not able to cope quickly with new situations because there were no agreed protocols. Health care provision suffered from fragility for the same reasons, although some staff training had taken place since the previous inspection.

For the court cells, although a number of recommendations from the previous inspection had been implemented, the poor physical conditions continued to make it impossible for detainees to be managed safely and decently.

Better physical facilities (both for the police custody suites and police cells), which were described as urgent in 2012, are no less so now. Governance still needs to be strengthened further. The improvements which have taken place illustrate the benefits of inspection; the distance still to be travelled reinforces our view, expressed in 2012, that custodial facilities need to be subject to regular, independent preventive monitoring in order to ensure that human rights are upheld and that meaningful accountability is maintained.

We noted that, of the 30 recommendations made for police custody suites in our previous report after our inspection of July 2012, 15 had been achieved, four had been partially achieved and 11 had not been achieved. Of the eight recommendations made for court cells, one had been achieved, one had been partially achieved and six had not been achieved.

This report provides a small number of recommendations to assist the prison and police services of the Cayman Islands to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

Nick Hardwick
HM Chief Inspector of Prisons

June 2015

Report A. Inspection of police custody suites

Section 1. Background and key findings

- I.1** HM Inspectorate of Prisons (HMIP) exercises its role in the UK as part of the National Preventive Mechanism, established following the UK's ratification of the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). It carries out these inspections in full partnership with HM Inspectorate of Constabulary. The Cayman Islands, a British Overseas Territory, are not a signatory in their own right to the Optional Protocol, which means that areas of detention on the islands are not subject to regular independent monitoring.
- I.2** HMIP was invited by the Governor of the Islands to undertake inspections of both police and court custody in a manner consistent with our inspections in England and Wales, and to follow up on the findings and recommendations of our previous inspection in 2012.
- I.3** Our inspections of police custody are informed by police law (in this case, that of the Cayman Islands), but they are based on a published set of *Expectations for Police Custody*¹ about the appropriate treatment of detainees and conditions of detention, developed by HMIP and HMIC to assist best custodial practice.
- I.4** At the time of the inspection, Royal Cayman Islands Police Service (RCIPS) had a total of seven police stations, five of which had custody facilities, including the remote islands of Cayman Brac and Little Cayman, which we did not visit.
- I.5** The custody facilities were located as follows:

Police station	Number of cells
George Town	16
Bodden Town	1
Marine base	2
Cayman Brac	2
Little Cayman	1

¹ <http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm>

Strategy

- I.6** Since the previous inspection, there had been some movement towards a consistent, strategic approach to custody work. Guidance documents had been written, and an overall custody policy had been drafted, awaiting sign-off. Work had been done to learn good practice from other jurisdictions. In day-to-day operations, there was good liaison between police and other agencies, but such operational cooperation did not provide a sound basis for dealing with unforeseen eventualities, and there was still a clear need for written agreements and protocols for joint working, with regular, if not frequent, meetings to review any issues.
- I.7** All staff working in custody had been trained to work there. The use and retention of closed-circuit television (CCTV) for evidential purposes had improved. All uses of force in custody were recorded, with dissemination of lessons learned.
- I.8** A key section of the George Town custody suite which was normally used for women and children had been unavailable for that use for the previous two and a half years because it had been occupied by a man being detained voluntarily, on the grounds of his own safety. This had had an impact on the women and children held in police custody (see below). West Bay custody suite had been deemed unfit for occupation, and closed.

Treatment and conditions

- I.9** Detainees' perceptions of their treatment by staff were variable. There was evidence of an inconsistency in approach between members of staff, which illustrated the need for written operational standards.
- I.10** Women and children were kept separate from men, and women always had access to a female member of staff, but their accommodation was not suitable (see below). There was no provision for any with a disability. For those who spoke no English, interpreting was available only if someone could be found within the limited resources on the island to provide it.
- I.11** There was a thorough risk assessment template as part of the computer system used in booking in, and in continuing detainee care. However, assessment of and provision for the risks and needs of those being released from custody were purely informal, usually depending on family members.
- I.12** The conditions of the George Town custody suite had not improved and were extremely poor. Cells were dirty, windowless, hot and humid, with no air conditioning, except in staff areas. Cells contained obscene and gang-related graffiti and multiple ligature points, and there were no secure exercise yards. Detainees held there had no privacy. The new facility, which was designed to meet all custody needs, had still not been completed or commissioned, despite announced opening dates in 2014.
- I.13** The cell at Bodden Town was not fit for its present purpose. The most fit-for-purpose cellular accommodation was a suite of two cells in the secure police marine base at Newlands but it was never used, as custody staff were unavailable to cover it.
- I.14** Families were expected to provide clothing, bedding, toiletries and reading materials for detainees. Detainees said that they were offered meals regularly but that the quality of the food was poor. There was no formal system for providing social visits.

Individual rights

- I.15** Detainees were told their rights on arrival. Appropriate criteria were used to decide to admit to custody, and few were detained for more than 48 hours before release, bail or remand into prison custody. Saturday morning courts had been initiated in order to avoid unnecessary detention over the weekend. The provision of an appropriate adult to support a child held in custody was on an informal basis. Immigration detainees were no longer held routinely for extended periods in police custody.
- I.16** There was no automatic provision of free legal advice, but a list of lawyers who could give pro-bono advice was readily available in the suites. Custody records were given to solicitors on request. The system for complaints was not sufficiently clear and accessible.

Health care

- I.17** No health services were provided in police custody. Detainees suspected of being unwell were taken to the nearby hospital in George Town. The preparedness of police custody officers to identify and assist detainees with health problems had improved through appropriate training. Medicines management was appropriate.

Main recommendations

- I.18** **The United Kingdom should extend OPCAT to the Cayman Islands.** (Repeated recommendation 2.17)
- I.19** **There should be a strategic focus on custody that includes closing and replacing the existing custody suites to ensure a clean and decent environment in which detainees' safety is protected and their multiple and diverse needs are met. There should be custody-specific policies and procedures to protect the well-being of detainees against which the quality of care and services can be assessed.** (Repeated recommendation 2.18)

Section 2. Strategy

Expected outcomes:

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

- 2.1 A chief inspector was the senior lead for custody, supported by an inspector, who was the custody manager. Since the previous inspection, guidance documents had been drawn up for most aspects of police custody work, and these were a step forward. A single formal policy document for police custody was still in draft. The inspector had visited police custody operations in other jurisdictions, including England and Wales, and was well equipped to recommend and implement improvements.
- 2.2 We welcomed the fact that the custody suite at West Bay had been deemed unfit for occupation and taken completely out of use. We were assured that it could never be used as an emergency resource. It was a source of frustration to senior managers that, although the George Town building had been condemned for some years (as recorded in the previous inspection report), it was still in routine use as the main custody facility. The cells and the marine base, although in most respects more fit for purpose than any others in current use, were not used because of the unavailability of trained staff. The building of a new custody suite was well advanced (see below).
- 2.3 In the previous report, we mentioned a man being detained in the discrete six-cell area of George Town suite, which was normally used for women and children, in order to keep them separate from men. This person was still in the same accommodation. He was not being detained against his will, and was legally free to leave but had declined to do so, on the grounds of his own safety. A legal impasse had been reached, which had resulted in the man being held for two and a half years in unacceptable conditions; it had also resulted in detained women and children having to be held in unacceptable conditions in Bodden Town police station (see sections on respect and physical conditions).
- 2.4 At George Town, there were four custody sergeants, each of whom worked with two auxiliary constables; they each worked 12-hour shifts, ensuring a degree of continuity. At the other police stations, staff were relocated to the custody suite when required. All staff working in custody had been trained to work there. This applied both to regular custody staff and to others who might be deployed to custody duties on an occasional basis. A manager had recently spent a month with Greater Manchester Police, UK, and was passing on learning about good practice to colleagues in the Cayman Islands.
- 2.5 Custody records were kept wholly on a computer system. Full details, including risk, needs and case history, were therefore available at all custody suites.
- 2.6 All uses of force in custody were recorded, and the details copied both to the professional standards department for scrutiny and to the training officer to inform future staff training. The Prison Inspection Board (PIB) made visits to the custody suites every two or three months, and had made recommendations about the inadequate physical conditions at George Town (see section on physical conditions).
- 2.7 There were good informal links with other agencies, such as the courts administration, immigration and health services, and many issues were addressed through personal contacts. However, there were no formal protocols and agreements, or regular multi-agency meetings, to ensure effective joined-up handling of all operational contingencies. There were

current examples of situations where such understandings were lacking: for example, there were uncertainties about responsibility for a group of undocumented migrants rescued at sea.

Recommendations

- 2.8** There should be specific policies that establish clear standards of care for those detained in police custody. Standards should address all issues, but as a minimum include accommodation and environment, supervision, the management of risk, equality and diversity, and health. (Repeated recommendation 3.9)
- 2.9** There should be protocols and regular meetings with all agencies concerned with the detention and care of police detainees to develop, maintain and improve services. (Repeated recommendation 3.13)
- 2.10** Police custody cells should not be used for any other form of detention than those forms sanctioned under Cayman Islands police law

Section 3. Treatment and conditions

Expected outcomes:

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

Respect

- 3.1 Only one detainee said that he had been treated badly by staff while he was in custody. There was evidence of inconsistency between members of staff. Their approach to even straightforward practical issues, such as whether to give bedding and toiletries to a detainee, differed, which illustrated the need for written operational standards. One detainee reported: 'The officers try but there seem to be no set guidelines for managing those detained.' Another wrote: 'Some of the staff were nice but some were very insensitive'.
- 3.2 The booking-in area at George Town was in a separate area to the cells and new arrivals were always booked in without other detainees present. There were no private facilities for booking in at Bodden Town.
- 3.3 The occupation of the six-cell discrete area at George Town by one man (see section on strategy) meant that women and children were held at Bodden Town, the only other cell in regular use on Grand Cayman. On one recent occasion, four women had been held for at least one night in this cell, which was too small to house more than two people.
- 3.4 Women were able to speak to a female officer on arrival and at any time they requested to do so. Custody staff told us that they tried to meet the diverse needs of detainees but that there were no specific guidelines or detailed arrangements for meeting the needs of detainees with disabilities. The new building (not yet in use) contained a shower suitable for people with mobility difficulties, but there were no other adaptations for those with disabilities.
- 3.5 For most detainees who did not speak English, interpreting needs were met by staff who spoke languages other than English and by local contacts; however, no formal services from trained interpreters, or from a telephone interpreting agency, were available.

Recommendations

- 3.6 **There should be clear policies about how to manage the diverse needs of detainees, such as women, young people and those with disabilities, with which all staff working in custody should be familiar.** (Repeated recommendation 4.5)
- 3.7 **Independent interpreting services should be readily available.** (Repeated recommendation 5.10)

Safety

- 3.8 There was a thorough risk assessment template as part of the computer system used in booking in, and in continuing detainee care; it covered substance misuse issues, self-harm risk, dietary needs and other relevant areas. There was evidence that this was being used properly. Detainees in cells were checked reasonably frequently, and staff understood the

importance of gaining a response. However, there were no appropriately safe and sharp tools to cut a ligature.

- 3.9** Custody records were generally completed with sufficient information about when the detainee was checked, their safety and their frame of mind, although details of interactions between staff and detainees were not recorded. Managers checked the quality of custody records, although not in a systematic or structured way.
- 3.10** Closed-circuit television (CCTV) was installed in most areas, including some custody cells. Retention for evidential purposes had improved, as all recordings were routinely kept for 30 days and could be saved to a hard disk for permanent retention when there had been an incident.
- 3.11** There was no evidence of pre-release risk assessments, and custody records ended with a simple note of the outcome. Staff assured us that, in virtually all cases, detainees being released had friends or family able and willing to meet them and supply any immediate support needs, and that in the rare cases where this was not the case, arrangements could be made informally. There were no safety-net arrangements to provide for those who did not have such support.
- 3.12** Three detainees told us that they had been victimised, by insulting remarks rather than physical abuse. None said that force had been used on them. Use of force in custody was rare; documentation had been introduced, and those who used force completed a form giving full details of their part in and perceptions of the incident. Appropriate departments were copied in to these forms, and managers checked the adequacy of reporting and the appropriateness of the interventions recorded. There was no systematic monitoring of use of force by ethnicity, nationality, age, location and officers involved.

Recommendation

- 3.13** **There should be formal pre release assessment processes so that the Royal Cayman Islands Police Service (RCIPS) is assured that all detainees being released are able to get home safely and, for those being transferred to other criminal justice agencies, relevant information about risk or vulnerabilities is passed on.** (Repeated recommendation 4.11)

Physical conditions

- 3.14** The conditions of the George Town custody suite had not improved and were extremely poor. Cells were dark and dirty, and in the form of open cages, making each detainee visible to all the others. They were for multiple occupancy, with bunk beds resembling steel shelves. Ventilation was poor and the temperature in the cell area was oppressive, with no air conditioning, except in staff areas, although electric fans were used. Cells did not contain litter but there was extensive obscene and gang-related graffiti. There were ligature points on the mesh fronts and in many other places in the cells. The new facility, which was designed to meet all custody needs, had still not been completed or commissioned, despite announced opening dates in 2014 (see main recommendation 1.19).
- 3.15** None of the cells had a call bell and staff were not able to see the cells from their offices. This meant that detainees could not attract the attention of staff until they entered the cell area, unless they were spotted on the CCTV monitor in another office (see main recommendation 1.19).

- 3.16** The showers and toilets were reasonably clean and half the detainees asked said that they had been offered a shower. There were no exercise facilities but custody records showed that some detainees had been allowed into the open air, handcuffed, to smoke. There were no regular fire evacuation practices but there were sufficient handcuffs for detainees to be escorted from the building to a safe area if required.
- 3.17** The cell at Bodden Town was separated from the station's open office area only by mesh partitioning; there was complete visibility and audibility from the office area. It contained two mattresses and a steel toilet and basin, but no beds. It was not suitable for overnight use, or for any purpose other than as a temporary holding room.
- 3.18** The most fit-for-purpose cellular accommodation was a suite of two cells in the secure police marine base at Newlands but it was never used, as custody staff were unavailable to cover.
- 3.19** The new custody suite, near HMP Fairbanks, was a modular structure, built to a standard American design. Although not yet complete, it was clear that it would be much more fit for purpose than the present suites, providing clean, safe and suitable conditions for detainees, with facilities for visits and legal interviews, and separate accommodation for men, women and young people.

Recommendations

- 3.20** **Cells should be free from ligature points and graffiti. They should be clean, have natural light, be at a comfortable temperature and have a call bell. They should be for single use only.** (Repeated recommendation 4.19)
- 3.21** **The new custody suite should be brought into operation as a matter of urgency, and George Town custody suite closed.**
- 3.22** **The Bodden Town cell should be used only as a temporary holding cell.**

Detainee care

- 3.23** The separate six-cell area at George Town had been occupied by a male detainee for the previous two and a half years (see section on strategy). The door to his cell was left open so that he could also use the corridor, but his cell and the corridor were dark, with no natural light. He had no way of telling what time of day it was, had not been outside for several weeks and was clearly depressed. A television had been placed in the corridor for his use. His lawyer and his pastor visited each week.
- 3.24** Families were expected to provide clothing, bedding, toiletries and reading materials for detainees. One detainee said that he had been in custody for two days with no bedding, towel, spare clothing or toiletries. Staff present said that that was his bad luck: his family had turned against him. One manager said that the necessary items would be sourced from the prison in such cases, and another that the main store in the police station would be used. There was clearly no consistent policy or practice, and the outcome was that nothing was provided.
- 3.25** Breakfast was provided from a local café, and lunch and dinner from Northward prison. Detainees said that they were offered meals regularly but that the quality of the food was poor. Families often brought food in for their detained relative.

- 3.26** There was no formal system for providing social visits, in view of the short periods of detention, but custody records showed that clothing and cigarettes were handed in by friends and family. Detainees could meet briefly with them if they wished. A small selection of books was available.

Recommendation

- 3.27 Detainees should be provided with clothing, bedding, toiletries, reading materials and decent food from the RCIPS and not need to rely on family and friends.**
(Repeated recommendation 4.24)

Section 4. Individual rights

Expected outcomes:

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

Rights relating to detention

- 4.1 There were notices informing detainees of their rights, and staff said that they explained these to them on arrival; most detainees whom we asked said that they had been told their rights. However, there was no indication in custody records that staff checked detainees' understanding of them.
- 4.2 Decisions about bail were appropriately focused on the seriousness of the alleged offence, risk to the public and likelihood of continued offending, and were based on an objective algorithm. There was a 48-hour limit on detention, after which extension had to be approved by a magistrate: this occurred rarely, and only because of circumstances such as a public holiday. Detainees were produced promptly in court. Emergency courts had been introduced on Saturday mornings, in order to avoid unnecessary detention over the weekend.
- 4.3 There was no legal requirement for a review of detention by a senior officer before the end of the 48 hours; senior managers had experimented with review at set intervals, but had reverted to informal frequent checks on the justification of continued custody.
- 4.4 There was no formal system of appropriate adults for detained children, but informal arrangements were made with family members or social services.
- 4.5 Immigration detainees were no longer normally held in police cells (unless they were due to appear for a criminal offence). Refugees, most often from Cuba, were held in the immigration detention centre next to HMP Fairbanks. We were told that children under 18 were rarely held in police cells as a place of safety, even though Cayman Islands law permitted this.

Recommendations

- 4.6 **Custody staff should check that detainees understand their rights, and record this.** (Repeated recommendation 5.7)
- 4.7 **A strategic review should determine whether reviews of detention by a senior officer at fixed intervals of less than 12 hours should be made mandatory.**

Rights relating to police law

- 4.8 There was no automatic provision of free legal advice, but a list of local lawyers willing to offer advice on a pro-bono basis was displayed in the custody suites. Four detainees (out of seven questioned) said that a lawyer had not been present when they were interviewed.
- 4.9 Legal representatives were provided with copies of custody records on request. The small number of forensic samples taken in police custody suites were stored and handled appropriately.

Recommendation

4.10 Police interviews should not be conducted without the availability of legal advice.

Rights relating to treatment

4.11 Detainees were not routinely told how to make a complaint. We were told that they could do so directly to the custody inspector, but detainees were not aware of this. There was no standard form provided. Complaints were passed to the Professional Standards Unit.

4.12 There was CCTV coverage of the custody suite (see section on safety) and recordings were retained for a sufficiently long period for them to be scrutinised in the event of a complaint.

Recommendation

4.13 **Transparent procedures should be introduced that enable detainees to make a complaint about their treatment if necessary before leaving custody and receive a response within an acceptable time. This right should be explained to them on arrival, and again before they leave.** (Repeated recommendation 5.20)

Section 5. Health care

Expected outcomes:

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

Patient care

- 5.1 No health services were provided in police custody. Detainees suspected of being unwell, either at the point of arrest or in custody, were taken to the hospital in George Town. The journey time to the hospital was usually five minutes. The police expressed satisfaction with this arrangement, in that treatment was usually prompt. There was the potential for the situation to be less satisfactory once the police started using the new custody suite, as the distance travelled would increase.
- 5.2 There had been no detainee health care assessment but, following the previous inspection, there had been an attempt to institute a service level agreement between the police and health services. This work had not come to fruition so that, without performance indicators, the police were unable to determine if the treatment provided was appropriate to meet detainees' needs.
- 5.3 Custody staff told us that detainees could receive prescribed medications while in custody, subject to verification. One detainee we spoke to confirmed this.
- 5.4 Medicines were stored securely and medicines administration was appropriately documented.
- 5.5 Custody staff had been trained in first aid and cardiopulmonary resuscitation. An automated external defibrillator (AED) had been installed at George Town police station, which increased preparedness for an emergency. However, when we visited, the AED had been taken out on patrol with response officers, leaving the custody suite without access in an emergency. Basic first-aid kits were provided at each custody suite.

Recommendations

- 5.6 **Following occupation of the new police custody suite, the police should undertake a health needs analysis to determine if the current service delivery model provides an accessible and acceptable response to the health care needs of detainees.**
- 5.7 **There should be a service level agreement or memorandum of understanding between the Health Services Authority and the RCIPS, to ensure that detainees receive appropriate health care while in custody.** (Repeated recommendation 6.3)
- 5.8 **Police custody staff members should have access to an automated external defibrillator at all times.**

Substance misuse

- 5.9** There was no substance misuse service in the police custody suites. The custody staff had received training in how to recognise withdrawal from drugs or alcohol. Detainees suspected of withdrawing were taken to George Town Hospital. We were told that this occasionally happened with detainees suspected of alcohol withdrawal.

Mental health

- 5.10** There was no mental health service in the police custody suite. The custody staff had received training in how to recognise mental health problems. Persons suspected of having mental health problems were taken to George Town Hospital for assessment.
- 5.11** All persons detained under Mental Health Law, 2013 Section 7(1) ² had been seen by a medical officer within 12 hours. We were told that police custody is used regularly for this purpose. Police custody had not been used as a prescribed place of safety under an Observation Order.

Recommendation

- 5.12** **The police and Mental Health Commission should agree a method to identify how frequently police custody is used for detention under mental health legislation and if these detentions are clinically appropriate.**

² Where it appears to any constable that a person is, by reason of mental impairment or serious mental illness, an immediate danger, or is likely to become a danger to himself or others, he may take such person into protective custody.

Section 6. Summary of recommendations

Main recommendations

- 6.1** The United Kingdom should extend OPCAT to the Cayman Islands. (1.18, repeated recommendation 2.17)
- 6.2** There should be a strategic focus on custody that includes closing and replacing the existing custody suites to ensure a clean and decent environment in which detainees' safety is protected and their multiple and diverse needs are met. There should be custody-specific policies and procedures to protect the well-being of detainees against which the quality of care and services can be assessed. (1.19, repeated recommendation 2.18)

Recommendations

Strategy

- 6.3** There should be specific policies that establish clear standards of care for those detained in police custody. Standards should address all issues, but as a minimum include accommodation and environment, supervision, the management of risk, equality and diversity, and health. (2.8, repeated recommendation 3.9)
- 6.4** There should be protocols and regular meetings with all agencies concerned with the detention and care of police detainees to develop, maintain and improve services. (2.9, repeated recommendation 3.13)
- 6.5** Police custody cells should not be used for any other form of detention than those forms sanctioned under Cayman Islands police law (2.10)

Treatment and conditions

- 6.6** There should be clear policies about how to manage the diverse needs of detainees, such as women, young people and those with disabilities, with which all staff working in custody should be familiar. (3.6, repeated recommendation 4.5)
- 6.7** Independent interpreting services should be readily available. (3.7, repeated recommendation 5.10)
- 6.8** There should be formal pre release assessment processes so that the Royal Cayman Islands Police Service (RCIPS) is assured that all detainees being released are able to get home safely and, for those being transferred to other criminal justice agencies, relevant information about risk or vulnerabilities is passed on. (3.13, repeated recommendation 4.11)
- 6.9** Cells should be free from ligature points and graffiti. They should be clean, have natural light, be at a comfortable temperature and have a call bell. They should be for single use only. (3.20, repeated recommendation 4.19)
- 6.10** The new custody suite should be brought into operation as a matter of urgency, and George Town custody suite closed. (3.21)

- 6.11** The Bodden Town cell should be used only as a temporary holding cell. (3.22)
- 6.12** Detainees should be provided with clothing, bedding, toiletries, reading materials 21 and decent food from the RCIPS and not need to rely on family and friends. (3.27, repeated recommendation 4.24)

Individual rights

- 6.13** Custody staff should check that detainees understand their rights, and record this. (4.6, repeated recommendation 5.7)
- 6.14** A strategic review should determine whether reviews of detention by a senior officer at fixed intervals of less than 12 hours should be made mandatory (4.7)
- 6.15** Police interviews should not be conducted without the availability of legal advice. (4.10)
- 6.16** Transparent procedures should be introduced that enable detainees to make a complaint about their treatment if necessary before leaving custody and receive a response within an acceptable time. This right should be explained to them on arrival, and again before they leave. (4.13, repeated recommendation 5.20)

Health care

- 6.17** Following occupation of the new police custody suite, the police should undertake a health needs analysis to determine if the current service delivery model provides an accessible and acceptable response to the health care needs of detainees. (5.6)
- 6.18** There should be a service level agreement or memorandum of understanding between the Health Services Authority and the RCIPS, to ensure that detainees receive appropriate health care while in custody. (5.7)
- 6.19** Police custody staff members should have access to an automated external defibrillator at all times. (5.8)
- 6.20** The police and Mental Health Commission should agree a method to identify how frequently police custody is used for detention under mental health legislation and if these detentions are clinically appropriate. (5.12)

Report B. Inspection of court cells

Section 7. Background and key findings

- 7.1** This was HMIP's second inspection of court custody facilities in the Cayman Islands. Court custody inspections have their own set of Expectations, which describe the standards of treatment and conditions that we expect each court custody suite to achieve for people in its custody, grouped under three inspection areas: leadership, strategy and planning; individual rights; and treatment and conditions.
- 7.2** The courts in George Town were under the remit of the Chief Justice of the Cayman Islands, and their operation was supervised by the court administrator on behalf of the Judicial Administration. Cooperation between police and prison staff on the handover of responsibility for detainees had improved, although there was no formal written protocol to define their responsibilities. Video-link to the men's prison was well used for court purposes.
- 7.3** Detainees were potentially subject to abuse and assault because they had to pass through public areas on arrival at the custody suite.
- 7.4** There was only basic provision for detainees' practical needs such as food. Women were held separately from men, and always supervised by female staff, and children were dealt with separately from adults. The use of handcuffs was subject to individual risk assessment.
- 7.5** The facilities were cramped, dark and often crowded, with a great deal of graffiti. Detainees could not consult legal advisers in private.

Main recommendation

- 7.6** **Cell accommodation should provide privacy and sufficient space for each detainee.** (Repeated recommendation 8.29)

Section 8. Leadership, strategy and planning

- 8.1** The courts in George Town were under the remit of the Chief Justice of the Cayman Islands, and their operation was supervised by the court administrator on behalf of the Judicial Administration. Cooperation between police and prison staff on the handover of responsibility for detainees had improved, and in general there was more regular communication between managers in the courts, police, prison, health care agencies and other stakeholders. New leadership at the prisons had assisted this process. There was good liaison between the head of security for the court building and the prison and police staff (the head of security was employed by the RCIPS but reported operationally to the courts administrator). It was also useful that the five security staff at the court were auxiliary constables with powers of search and arrest.
- 8.2** We found that the disagreement over transporting prisoners to the prisons had been resolved since the previous inspection and police staff understood that a detainee did not become the responsibility of the prison until he or she had been transported there and the warrant for imprisonment delivered. However, there was no formal written protocol to define their responsibilities.
- 8.3** Good facilities for holding hearings by video-link from Northward Prison had been introduced and were well used.

Recommendation

- 8.4** **The roles and responsibilities of the organisations delivering court custodial services should be clearly set out in a written service level agreement.** (Repeated recommendation 8.8)

Section 9. Treatment and conditions

Respect

- 9.1** The vehicle which we saw used for transporting detainees to and from prison was modern and clean, with separate accommodation for women and young people. Police detainees were normally transported the short distance to the court in a police car.
- 9.2** The disembarkation area was in a public space, increasing the risk of flight and putting detainees at risk of abuse or assault. To counter this risk, detainees were put in restraints; at times, these took the form of leg shackles, which was particularly oppressive and demeaning. Staff mitigated the risk as well as they could by bringing the exit door of the vehicle as near as possible to the relevant door of the building. This risk was greater for those whose cases were heard in the nearby Kirk House court building.
- 9.3** Food was provided at mealtimes from the prison and was not always at an acceptable temperature. Drinking water was freely available. There were no facilities for religious needs, such as prayer mats or religious scriptures. No books, newspapers or magazines were available, although there was insufficient light for reading in most of the cell area.

Recommendations

- 9.4** **Detainees should not be required to pass through public areas on their way into or between courts.** (Repeated recommendation 8.27)
- 9.5** **Food provided for detainees should be fresh and at the correct temperature.** (Repeated recommendation 8.26)

Safety

- 9.6** There was no court-based provision for discrete risk or needs assessments, or clear systems to protect and support detainees specifically in court custody. However, this was acceptable as detainees remained in the continuous care of police or prison staff. The security staff at the court buildings had been trained in custody work and were able to assist the police and prison staff in their custodial duties. As special constables in their own right, and police employees, they had the powers and the knowledge to give such assistance in the appropriate way. Small amounts of property could be stored at the court, and if any person needed support or help on being discharged from the court, court staff gave informal assistance in liaison with the custody sergeant.
- 9.7** Women were held separately from men. The cell area was divided by a lockable gate, to achieve this separation. We were assured that women were always supervised by female staff.
- 9.8** Children were escorted separately from adults, taken through a discrete entrance into the court building and held in a different waiting room, and their case was normally heard in a courtroom of informal design, subject to risk assessment.

- 9.9** Supervision was good, with CCTV and the continual presence of staff. Handcuffs were applied only if an individual risk assessment indicated a need for them, even in less secure areas. The docks in the two main courtrooms were not secure, but handcuffs were only authorised in the most exceptional circumstances.

Physical conditions

- 9.10** Accommodation for detainees consisted of three small rooms, with bench seating around three sides and mesh partitioning between the cells and onto the corridor. The temperature was kept reasonable by air conditioning. Rooms were clean but dark, with little natural light. There was extensive graffiti, some gang related, on the walls, including the name and telephone number of a woman, implying the offering of sexual services. Others included men's first names, with threats. One holding room, beyond a gate on the corridor, was used for women or young people. We saw it in use for two young people and it was particularly dark, as there was no electric light in the corridor outside it.
- 9.11** Space was limited; during the inspection, some detainees had to be left standing in the corridor (see main recommendation 7.6).
- 9.12** There was a single, unhygienic washroom, in poor condition, with a stainless steel toilet and basin. Staff carried out a daily health and safety check on each cell.

Recommendation

- 9.13** **Holding rooms should be cleaned of graffiti, and should have sufficient light.**
(Repeated recommendation 8.28)

Health care

- 9.14** No health services were provided in court custody. Court custody officers were trained in first aid, and first-aid kits (but no automatic external defibrillator) were available in the court building. Detainees in court custody could receive prescribed medications, subject to verification. Those with medical issues requiring urgent attention were taken to the nearby George Town hospital, normally by ambulance.

Section 10. Individual rights

- 10.1** Records for authorisation of detention were kept and detainees were quickly moved to prison after their hearing had concluded. Valid warrants were in place and there was no evidence of long waits in the court cells. For those coming from prison, prison staff escorted them and remained at the court, taking promptly back to the prison any whose cases finished early.
- 10.2** There were no suitable facilities for consultation with legal advisers. We saw prisoners speaking to their lawyers through the cell gates, in full view and hearing of staff and other detainees.
- 10.3** Interpreters were arranged through the police contacts but there was no formalised service covering all potential languages.
- 10.4** Although detainees were not told how they could make a complaint, we were told that they could use the court complaints system, although this had not been used for complaints about detention. The normal avenue of complaint was to the police or prison service, whose staff supervised them in court custody. There was no independent monitoring body for court custody.

Recommendation

- 10.5** **Detainees should have facilities and sufficient time for private interviews with counsel.** (Repeated recommendation 8.14)

Section 11. Summary of recommendations

Main recommendation

- 11.1 Cell accommodation should provide privacy and sufficient space for each detainee. (7.6, repeated recommendation 8.29)

Recommendations

Leadership, strategy and planning

- 11.2 The roles and responsibilities of the organisations delivering court custodial services should be clearly set out in a written service level agreement. (8.4, repeated recommendation 8.8)

Treatment and conditions

- 11.3 Detainees should not be required to pass through public areas on their way into or between courts. (9.4, repeated recommendation 8.27)
- 11.4 Food provided for detainees should be fresh and at the correct temperature. (9.5, repeated recommendation 8.26)
- 11.5 Holding rooms should be cleaned of graffiti, and should have sufficient light. (9.13, repeated recommendation 8.28)

Individual rights

- 11.6 Detainees should have facilities and sufficient time for private interviews with counsel. (10.5, repeated recommendation 8.14)

Appendices

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Andrew Rooke	HMIP inspector
Paul Tarbuck	HMIP health services inspector
Rachel Murray	HMIP researcher
Alissa Redmond	HMIP researcher

Appendix II: Progress on recommendations from the last report: Police custody suites

The following is a summary of the main findings from the last report and a list of all the recommendations made. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Strategy

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

Main recommendations

The United Kingdom should extend OPCAT to the Cayman Islands. (2.17)

Not achieved (recommendation repeated, 2.18)

There should be a strategic focus on custody that includes closing and replacing the existing custody suites to ensure a clean and decent environment in which detainees' safety is protected and their multiple and diverse needs are met. There should be custody-specific policies and procedures to protect the well-being of detainees against which the quality of care and services can be assessed. (2.18)

Not achieved (recommendation repeated, 2.19)

Recommendations

There should be specific policies that establish clear standards of care for those detained in police custody. Standards should address all issues, but as a minimum include accommodation and environment, supervision, the management of risk, equality and diversity and health. (3.9)

Partially achieved

Policies, adverse incidents and lessons learnt from other police jurisdictions should be used for the monitoring of custody facilities and services and to ensure accountability. (3.10)

Partially achieved

All staff who work in custody should be trained to do so. (3.11)

Achieved

There should be closed-circuit television in all areas of custody. Images should be kept for at least 30 days. (3.12)

Achieved

There should be protocols and regular meetings with all agencies concerned with the detention and care of police detainees to develop, maintain and improve services. (3.13)

Not achieved

Treatment and conditions

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

Recommendations

There should be clear policies about how to manage the diverse needs of detainees, such as women, juveniles and those with disabilities, with which all staff working in custody should be familiar. (4.5)

Not achieved (recommendation repeated, 4.6)

Women should be able to speak to a female officer on arrival and at any time they request to do so. (4.6)

Achieved

The initial booking-in process should include information about potential risks, and custody records should include all interactions with the detainee, including regular rousing to ensure detainee safety. (4.10)

Achieved

There should be formal pre release assessment processes so that the Royal Cayman Islands Police Service (RCIPS) is assured that all detainees being released are able to get home safely and, for those being transferred to other criminal justice agencies, relevant information about risk or vulnerabilities is passed on. (4.11)

Not achieved (recommendation repeated, 4.13)

The RCIPS should record all uses of force in custody and then monitor them by ethnicity, nationality, age, location and officers involved, in line with good practice. (4.12)

Achieved

Cells should be free from ligature points and graffiti. They should be clean, have natural light, be at a comfortable temperature and have a call bell. They should be for single use only. (4.19)

Not achieved (recommendation repeated, 4.20)

Custody staff should rouse detainees regularly if needed, and record that they have done so in the detainee's custody records. (4.20)

Achieved

The RCIPS should carry out regular fire evacuation practices of the whole custody suite, to ensure that staff are aware of their roles and responsibilities. (4.21)

Not achieved (recommendation repeated, xx)

Detainees should be provided with clothing, bedding, toiletries, reading materials and decent food from the RCIPS and not need to rely on family and friends. (4.24)

Not achieved (recommendation repeated, 4.27)

Individual rights

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

Recommendations

Custody staff should check that detainees understand their rights, and record this. (5.7)

Not achieved (recommendation repeated, 5.6)

Immigration detainees held in police cells should be transferred immediately to immigration services detention. (5.8)

Achieved

Police cells should not be used as a place of safety for juveniles or vulnerable adults. (5.9)

Achieved

Independent interpreting services should be readily available. (5.10)

Not achieved (recommendation repeated, 4.7)

Free legal representation should be offered to all detainees, and police interviews should not be conducted without the availability of legal advice. (5.14)

Partially achieved

Detainees should be able to consult with legal advisers in privacy in a suitable room. (5.15)

Achieved

Custody records should be freely available to legal representatives. (5.16)

Achieved

A forensic samples management system should be established to ensure that samples are sent to the forensic laboratory promptly. (5.17)

Achieved

Transparent procedures should be introduced that enable detainees to make a complaint about their treatment if necessary before leaving custody and receive a response within an acceptable time. This right should be explained to them on arrival, and again before they leave. (5.20)

Partially achieved (recommendation repeated, 5.12)

Health care

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

Recommendations

There should be a service level agreement or memorandum of understanding between the Health Services Authority and the RCIPS to ensure that detainees receive appropriate health care while in custody, irrespective of costs. (6.3)

Not achieved (recommendation repeated, 6.7)

Detainees should be able to receive prescribed medication while in custody. (6.4)

Achieved

All staff who work in custody should have first-aid and resuscitation training and have access to the necessary equipment in the police station. (6.5)

Achieved

All custody staff should be trained and able to recognise the signs and symptoms of withdrawal from drugs or alcohol and take appropriate action. (6.8)

Achieved

All custody staff should have mental health awareness training. (6.10)

Achieved

Appendix III: Progress on recommendations from the last report: Court cells

Leadership, strategy and planning

Recommendations

The roles and responsibilities of the organisations delivering court custodial services should be clearly set out in a written service level agreement. (8.8)

Not achieved (recommendation repeated, 9.4)

Court hearings should be conducted by video link where possible. (8.9)

Achieved

Treatment and conditions

Food provided for detainees should be fresh and at the correct temperature. (8.26)

Not achieved (recommendation repeated, 10.5)

Detainees should not be required to pass through public areas on their way into or between courts. (8.27)

Not achieved (recommendation repeated, 10.4)

Holding rooms should be cleaned of graffiti. (8.28)

Not achieved (recommendation repeated, 10.13)

There should be sufficient cell space to provide privacy and reasonable space for each detainee. (8.29)

Not achieved (recommendation repeated, 8.6)

Individual rights

Detainees should have facilities and sufficient time for private interviews with counsel. (8.14)

Not achieved (recommendation repeated, 11.5)

Detainees should have access to the means for complaining about court detention. (8.15)

Partially achieved