OMBUDSMAN
CAYMAN ISLANDS

OFFICE OF THE OMBUDSMAN
OWN-MOTION INVESTIGATION
CAYMAN ISLANDS DETENTION CENTRE

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The Ombudsman is an impartial and independent office of Parliament that acts as the Cayman Islands' guardian of fairness, transparency and accountability.

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Authority: Own-Motion Investigation of Royal Cayman Islands Police Service, Cayman Islands Detention Centre

Report prepared by the Office of the Ombudsman
Date: (TBD)

Report made under the authority of section 11(1) of the Complaints (Maladministration) Act (2018 Revision)

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Executive Summary:

The Office of the Ombudsman (OMB), after receiving several reports of prisoner injury or attempted self-harm at the Cayman Islands Detention Centre (CIDC) in a relatively short period, became concerned regarding the security of the facility and the potential risks associated with operating it. OMB opened an own-motion investigation (OMI) at the CIDC in May 2025 and completed an Interim Report containing findings and recommendations, which was sent to the Commissioner of Police and HE the Governor in September 2025. A summary of findings from that Interim Report was made public in early October 2025 and was released to the Cayman Islands news media.

In December 2025, the Office of the Commissioner of Police provided a substantial response to the 18 recommendations contained in the Interim Report. The separate responses and actions are contained in this completed final report and a summary of the actions taken in response to the Interim Report's findings can be found in Appendix A of this document.

This final OMI report made further findings and an additional 12 recommendations based on additional investigations conducted by OMB staff. Among the more serious findings in this report are:

- A fire alarm system outage at CIDC persisted for approximately five years before it began to be addressed in 2024.
- An attempted detainee escape was facilitated by an external security door being left ajar.
- Internal security doors at CIDC are routinely being left ajar.
- RCIPS policy requirements that detainees be searched upon entry to the CIDC were not adhered to in many cases.
- It is probable that both attorney-client discussions and police interviews were not able to be conducted confidentially at CIDC
- There have been numerous incidents of attempted self-harm within CIDC in the past two years and attending officers are not always appropriately trained to deal with these situations.
- CIDC officers are often not performing hourly prisoner welfare checks as required by RCIPS policy, or are not recording these checks when they are done.
- Understaffing and sheer volume of work both serve to significantly hinder CIDC officers from completing their duties effectively.
- Language barriers with some detainees can create risks for CIDC officers dealing with these individuals, especially as translators are often not available after hours.

The above are not exhaustive of the findings contained in this final OMI report. Readers are urged to review the entire document to understand the full context and findings, as well as the recommendations made by the Ombudsman. OMB will continue to follow up with the RCIPS command on outstanding recommendations to ensure all recommendations are met, to the extent possible.

Summary of incidents:

The following five reports have come to the attention of the Office of the Ombudsman (OMB) since October 2023:

Incident - 21 September 2024 – (Individual #1) – The detainee had allegedly made threats to kill officers. As he was placed in the cell, his hand was still in the door when it was slammed shut, cutting off the end of his thumb. There was a delay in checking him and custody staff later discovered the injury. He was transferred to the hospital. He filed a signed complaint and the matter was investigated under the authority of the Police (Complaints by the Public) Act. A final investigation report was sent to the Commissioner of Police.

Incident - 15 September 2024 – (Individual #2) – The detainee was in custody at the Cayman Islands Detention Centre (CIDC) when he drank half a bottle of rubbing alcohol. EMS was immediately requested and he was taken to the Health Services Authority (HSA) where he was treated and later released with no serious injury. The matter was closed due to no signed complaint being received and no serious harm occurring.

Incident - 5 December 2024 – (Individual #3) – While in the CIDC cell, the detainee was being given his medication by custody staff when he grabbed the medication packet through the cell hatch and ingested the contents (antidepressants). The detainee was taken to HSA and treated. OMB has the evidence in this matter and will investigate if we receive a signed complaint form.

Incident - 4 December 2024 – (Individual #4) **–** The detainee was in a cell at CIDC and was observed using a bedsheet to tie around his neck. The sheet was anchored to the toilet in the cell. The detainee was kept under full-time observation while in detention. No serious harm was reported and no formal complaint was ever received.

Incident - 4 October 2023 – (Individual #5) – The detainee allegedly defecated on the cell walls and tied a bed sheet around their neck. A visible check by custody officers showed no harm or injury, but the Chief Inspector still requested an ambulance to take the detainee to HSA for a full examination

and mental health assessment. No serious harm was reported and no signed complaint was received, so the case was closed.

The above five incidents were reported to OMB in the 15 months preceding the opening of this Own-Motion Investigation (OMI) in May 2025 and reports of other, similar self-harm or injury incidents at the Cayman Islands Detention Centre (CIDC) were received since that time. In addition, at least two local attorneys have engaged with OMB, expressing concern about issues taking place at the CIDC.

OMB's complaints unit has reviewed some of the matters above and received preliminary information about others. However, the Ombudsman considered that a more in-depth review was necessary to ensure and improve safety for both detainees and RCIPS officers. The sheer number of incidents has prompted some urgency on the part of OMB to review these matters from a policy/procedure level under the Complaints (Maladministration) Act (2018 Revision) (the Act).

Section 11(1) of the Act provides as follows:

11. (1) The Ombudsman shall not make an investigation without first receiving a written complaint ***unless he is of the opinion*** *or the Legislative Assembly resolves* ***that there are reasons of special importance that make investigation by the Ombudsman desirable in the public interest.***

In light of the volume of incidents occurring at the CIDC within a relatively short time and given the critical nature of the issues raised, particularly as they pertain to individuals who may represent either a significant security risk or heightened vulnerability, the Ombudsman has determined that there exists a clear and compelling public interest in undertaking a comprehensive review of the facility's operations.

Section 10 (3) of the Act allows the Ombudsman to investigate "any course of conduct or anything done or omitted by any person in the exercise of administrative functions respecting any business of the government" unless exempted under the Act. The matters set out below are within the power of the Ombudsman to investigate.

Prior to formally commencing this investigation, the OMB undertook the additional step of consulting with senior commanders of the Royal Cayman Islands Police Service (RCIPS) as well as defense attorneys whose clients are frequently held at the CIDC. These consultations were aimed at soliciting informed perspectives on potential areas of concern to be addressed during the investigation. Input received from these stakeholders was incorporated into the development of the investigation plan. The response from all parties was uniformly positive, with a broad consensus that the CIDC represents a high-risk operational environment warranting thorough examination.

Issues for investigation:

The OMB's preparatory work for this OMI focused on three principal areas of concern, each comprising several sub-issues. A number of these matters, but not all, were flagged in an OMB interim report presented to the Commissioner of Police in September 2025 and our office has received significant feedback on the implementation of recommendations made in that interim report. This full report seeks to further identify issues in the operation of the CIDC that the Ombudsman considers to be operational and/or reputational risks to the RCIPS; it will also update members of the public on the progress of implementing OMB's recommendations made in the interim report.

Issue 1 – Medical/safety procedures at the CIDC

- **Uncertainty regarding current medical response procedures**

Summary of Findings: The current requirements for medical transportation of detainees, if needed, may remove one or more Auxiliary Constables (ACs) from shift availability for hours at a time. CIDC supervisors were surprised this was occurring and noted that other arrangements should be made. A departmental directive has now been issued in relation to the transport procedure.

- **Building fire alarm outage**

Summary of Findings: The CIDC fire alarm system has been nonfunctional for several years, and apparently, this issue went unaddressed during a period between 2019 and 2024. More recent efforts were being made to repair it. The RCIPS has provided the Ombudsman with a full report on those efforts to date.

- **Recurring incidents of attempted self-harm**

Summary of Findings: In addition to the five incidents noted above, there have been a handful more similar occurrences of attempted self-harm reported to OMB during the course of this investigation. We have reviewed several instances and have made recommendations regarding training and staffing to address these matters. Additional new recommendations were included under this subheading, as this issue was not addressed in the Interim Report.

Issue 2 – Record keeping/Intake procedures at the CIDC

- **Security doors left ajar in multiple locations**

Summary of Findings: During several visits by OMB staff, it was noted that internal security doors at the CIDC were left ajar. There are various reasons this is occurring. However, this remains a serious security risk.

- **Cell inoperable due to overhead light damage**

Summary of Findings: At the time of OMB's visits to the CIDC, one of the 12 cells (Echo Pod, cell E-2) was out of order. The overhead light in the cell had been damaged by one of the detainees, according to the RCIPS. The light had not been repaired in more than two months at the time of the OMB's visits and RCIPS officers were unable to use the cell as a result.

- **Detainee welfare checks**

Summary of findings: It was clear from OMB's review of the detainee logs that people being held in the CIDC cells were either not being checked each hour in accordance with the RCIPS Custody of Prisoners policy or, if these checks were being done, they were not recorded. Further, on many of the computer records entries, information about the prisoner's welfare and behaviours were not included. Additional new recommendations were included under this subheading, as this issue was not addressed in the Interim Report.

- **General intake procedures**

Summary of Findings: Requirements in the RCIPS Custody of Prisoners Policy for each detainee to be searched upon entry to the CIDC were not complied with regularly. Also, there is no current policy to guide the use of metal detector wand scans on detainees. There was also some concern regarding the level of supervision of detainees in the booking area, as well as the security of documents containing personal information that are being kept in the RCIPS custody office. Additional new recommendations were included under this subheading, as this issue was not addressed in the Interim Report.

- **Detainee interviews/attorney consultations**

Summary of Findings: The OMB investigation found it probable that both attorney-client discussions and suspect interviews conducted at CIDC cannot be conducted confidentially, simply due to the size and capacity issues at the facility. Additionally, we note that there are two large rooms within the CIDC that are not currently in use which could possibly be used to conduct interviews or attorney-client meetings. Additional new recommendations were included under this subheading, as this issue was not addressed in the Interim Report.

Issue 3 – Staffing/training issues at CIDC

- **Current staffing levels for Auxiliary Constables and CIDC Sergeants**

Summary of Findings: Prior to conducting site visits, OMB met with senior officers of the RCIPS who suggested the ideal level of staffing at CIDC was four ACs and one Sergeant per 12-hour shift. This staffing level was never observed during any of our nine visits to the CIDC and staffing levels for entire shifts were sometimes as low as two ACs and one Sergeant. RCIPS has now responded with a plan to essentially double the available staff for CIDC operations.

- **Training availability**

Summary of Findings: CIDC officers whose files were reviewed by OMB participated in many and varied training programmes, including the required officer safety training. However, there were gaps in custody-specific training which the RCIPS was aware of and noted plans to address during 2026.

- **Language barriers**

Summary of Findings: There were a handful of incidents during the OMB's stationing at the CIDC in which detainees struggled to understand ACs, Sergeants, and even the arresting officers. A number of individuals being booked into the CIDC were clearly English as a Second Language (ESL), and it seemed officers needed assistance in particular with Spanish, Hindi, and Tagalog. It was found that, in most cases, CIDC Sergeants would not have access to a translator during the intake procedure overnight and on weekends, although translators would be made available for officers' investigative interviews. Additional new recommendations were included under this subheading, as this issue was not addressed in the Interim Report.

Investigation Procedures:

In accordance with the procedures of the Act, the Ombudsman identifies specific issues at the outset of every formal investigation. However, the process for an OMI differs slightly as such inquiries are initiated internally by the Ombudsman rather than in response to a complaint made by a member of the public. As noted above, several matters were brought to the attention of the Ombudsman which contributed to the determination that a broader investigation was warranted. An investigation plan was subsequently developed to address the specific issues requiring examination. These issues are typically outlined in an opening letter to the chief officer of the relevant government entity. In this instance, the opening letter was sent to the Commissioner of Police on 21 May 2025.

Prior to the issuance of the opening letter, OMB engaged in preliminary consultations with both the Assistant Commissioner of Police and the two most senior supervisors at the CIDC. These discussions were intended to get their perspectives and relevant operational insights that could inform the scope and direction of the investigation.

Several of the matters now under review in this OMI were developed from the input they provided. In accordance with standard procedure, the chief officer of the relevant government entity (in this case the Commissioner of Police) designated an investigation liaison to assist the OMB with its inquiries. Upon completion of the investigation, a final investigation report will be provided to the Commissioner of Police and HE the Governor. The report will also be submitted to the Parliamentary Oversight Committee for tabling in Parliament.

Summary of Investigation:

OMB investigators conducted a total of nine site visits at the CIDC facility on Fairbanks Road at different times and dates, between 5 June and 23 June 2025. The visits included overnight shifts and public holidays and investigators were stationed there between 4-5 hours each visit. The visits were arranged beforehand with the knowledge of the RCIPS CIDC Inspector and all CIDC staff members were made aware this investigation was occurring.

Several OMB employees participated in the site visits, engaged with RCIPS personnel, observed intake and detainee handling procedures, captured photographic evidence and obtained documentation.

Issue 1: Medical and Safety Procedures

• Uncertainty regarding current medical response procedures

An incident occurring between the late evening of 14 June and early morning of 15 June involved the transport of a detainee from CIDC to the Cayman Islands Hospital.

The individual, reportedly intoxicated and with limited English comprehension, was unable to respond clearly to questions put to him by the Sergeant on duty. Due to his confusion and the uncertainty of his medical condition, an ambulance was called.

In accordance with Health Services Authority (HSA) policy, a CIDC Auxiliary Constable (AC) accompanied the detainee in the ambulance to ensure the safety of medical personnel. This procedure, however, resulted in the temporary removal of one AC from duty, reducing the already limited staffing capacity. If the detainee was not admitted, a second officer would be required to retrieve both the detainee and the accompanying AC, further straining resources. This was occurring on a shift staffed by one Sergeant, one PC and two ACs and effectively took half the CIDC staff off their CIDC duties for a time.

When questioned by OMB, the supervising Inspector expressed surprise at this arrangement, noting that such transports should ideally be handled by the arresting officers or coordinated with other RCIPS units. The issue may have been that the detainee in this case started behaving in a concerning manner after the arresting officers left the CIDC to return to patrol. Even so, the CIDC Inspector said arrangements should have been made to contact another RCIPS unit to escort the detainee and this should have been coordinated with supervisors at George Town Police Station.

The RCIPS Guidance on Detention and Handling of Persons in Police Custody makes provision for hospital transport in section 2.1.4., providing that, in the event of a hospital transport: “a police officer or designated escort officer should remain with that detainee, except where bail has been granted to ensure that they do not escape from detention.”

However, it does not specify which unit should provide the escort.

Following the CIDC site visits on 29 June 2025, a separate incident was brought to the attention of OMB, revealing a breakdown in communication between HSA and RCIPS. In that case, a detainee admitted to the hospital for treatment was later released without notification to RCIPS. The RCIPS had to go retrieve the detainee post-release and return him to CIDC. The Inspector confirmed the detainee had not been formally booked into CIDC prior to hospitalization and that HSA had failed to notify RCIPS as required.

Findings:

1. There is an existing policy on the transport and care of injured or sick detainees
2. The policy lacks clarity regarding which RCIPS unit is responsible for escort duties
3. The incident of 29 June highlights a serious communication failure between HSA and RCIPS, posing operational and security risks

The above matters were reviewed with the Commissioner of Police in the interim report, provided in September 2025. The following actions have been taken in response to recommendations made by the Ombudsman:

RCIPS response to OMB recommendations:

Recommendation 1 – Clarify Escort Responsibilities for Medical Transport

- *Amend the RCIPS policy on detainee transport to clearly designate which unit (CIDC or uniform patrol) is responsible for escort duties.*
- *Establish a standing protocol for coordination between CIDC and patrol units when detainees require hospitalisation.*

Status: Completed

Section 4.4 of the RCIPS Custody Policy assigns responsibility for medical escorts to the Investigating Officer and/or Service Delivery. The Ombudsman requested formal reinforcement through a directive from ACOP and the Superintendent of Service Delivery.

Update:

- A directive has been issued that clearly outlines the procedures for transporting detainees to health care facilities. The directive outlines the following:
  - i) Recording of risk assessment prior to transportation
  - ii) Minimum staff required for the escort
  - iii) Requirement for minimum staff to be maintained at CIDC to facilitate the hospital transportation.
  - iv) Clearly outlines the Duty Inspectors (A99) responsibilities re ensuring the safe staffing of the transportation and CIDC. The directive outlines the escalation process

- The HQ directive also outlines the requirement for breaks within CIDC where operationally possible and the Duty Inspector's responsibility. The Ombudsman received a copy of the directive on 17 December 2025.

Recommendation 2 – Strengthen Communication Between RCIPS and HSA

- *Develop a formal Memorandum of Understanding (MoU) between RCIPS and HSA outlining procedures for detainee admission, discharge, and notification responsibilities.*
- *Implement a shared communication log or alert system to ensure timely updates on detainee status.*

Status: In Progress
A significant meeting occurred on 4th November 2025 between the Assistant Commissioner of Police, the CIDC Inspector and HSA leadership to discuss improvements to the current arrangements. We looked at best practice from other jurisdictions in respect of managing detainee healthcare and vulnerabilities.

Outcomes:

- Agreement to develop a pilot Custody Health Model. This would look to pilot the physical placement of a healthcare professional within CIDC to ensure detainees have access to examination at point of detention being authorized and throughout their stay. Feasibility work is now being progressed.
- MOU drafting assigned to (a senior member of the HSA staff).
- Nursing and custody teams to conduct joint site visits.
- Data collection framework established for pilot evaluation.

• Building fire alarm outage

The fire alarm system at the CIDC, which is a modular building, has been non-functional for several years. Emails from the RCIPS Estates and Procurement Manager sent on 12 June 2025 indicated repairs were far along, but not completed.

"The system is approximately 90% completed. As at 6/6 the update from the service provider was "I have 3 items left to install to complete the project. I will be clearing them today hopefully and will advise when they are in hand for installation."

The CIDC Inspector provided the following additional information:

CIDC spoke with the US contractor managing the fire alarm system which has not been working since approximately 2020. Everything that's currently there and in place is working (sprinklers, triggers, alarms etc.) and they just have to test it. The contractor was scheduled to come down to do the inspection with the fire service. The issue appeared to be with the suction pump that pumps the water to the tank to send to CIDC in case of a fire. The contractor states the alarm system will work, but the question is whether it will be to the specifications of the fire service, which still needs to test it. If the suction power doesn't meet the requirements for testing, the CIG would have to procure a replacement system.

Additionally, the external water pipe supplying the sprinkler system requires replacement. It is believed, but not ascertained, that if a fire broke out at CIDC now, the sprinkler will activate but the water pressure may not be optimal.

The OMB noted that hand-held fire extinguishers within the facility had been inspected and were up to date at the time of our visits.

Since the OMB's recommendations were issued in the Interim Report produced in September 2025, the RCIPS has completed a thorough investigation concerning issues with the fire alarm system maintenance and operation. The findings contained in that report are summarised below:

"The review found that the prolonged failure of the fire alarm system resulted from systemic shortcomings in maintenance, documentation, escalation, and governance. No evidence was identified of planned maintenance, inspection, or formal reporting on the defective system between 2019 and 2024, and the defect was not escalated through official channels to senior leadership during this period. As a result, detainees were housed for several years without a functioning fire detection and alarm system, creating avoidable safety, operational, and compliance risks.

"The issue was first identified in 2019 and rediscovered in June 2024, at which point it was formally escalated and corrective actions were initiated. These actions included engaging Estates and Procurement to restore and certify the system, developing interim risk mitigation measures, updating fire safety procedures, and beginning improvements to internal reporting and oversight.

"Overall, the review concludes that the failure of the fire alarm system to be repaired over multiple years stemmed from weaknesses in governance, accountability, and assurance mechanisms rather than a single point of failure. To prevent recurrence, the report recommends strengthening fire safety governance; clarifying ownership and accountability for critical systems; establishing a formal inspection, testing, and maintenance regime; ensuring structured escalation for safety-critical defects; and introducing routine leadership reporting and oversight processes. Implementing these measures will improve compliance, enhance organizational assurance, and better safeguard both detainees and staff at the CIDC. [1]"

Findings:

1. The fire alarm system at the CIDC has been nonfunctional for a period of several years, during which the CIDC has continued operating
2. No adequate explanation has been given for why this situation occurred and was allowed to persist

The above matters were reviewed with the Commissioner of Police in the interim report, provided in September 2025. The following actions have been taken in response to recommendations made by the Ombudsman:

RCIPS response to OMB recommendations:

Recommendations 3–4 – Fire Alarm System Restoration, Certification & Root Cause Review

- *Expedite completion and certification of the fire alarm system, including inspection by the Cayman Islands Fire Service.*
- *Commission an independent review to determine why the system remained nonfunctional for such an extended period and provide a report on the findings to the Ombudsman within 3 months of the date hereof.*
- *Establish a maintenance schedule, implement accountability measures and reporting mechanism to prevent recurrence.*

[1] RCIPS – Review of the CIDC Building Fire Alarm System – 26 November 2025

Status: In Progress / Review Completed

A. Fire Alarm Restoration & Testing
A full facility fire system test and evacuation test took place on 5th December 2025 at 10:00 AM. The test was successful.

Key Elements:

- PWD confirmed generator board failure, requiring replacement
- Temporary fix: generator set to AUTO mode for testing. This replacement order has been submitted and estimated to be fixed within the next 4 weeks (as at date of response, December 2025).
- Testing included activation of the manual pull station at Sergeant's desk, triggering:
  - Fire alarm input
  - Magnetic door release system (separate subsystem)

Regular tests of the fire alarm will now take place. Full certification of the alarm has been submitted by Building Control and expected to be completed in the next four weeks (as at date of response, December 2025) with the Fire Service.
Details of the test are attached as appendix I**I**

B. Independent Review into why the fire alarm system remained nonfunctional. (Completed)
The internal review was completed 26 November 2025, outlining systemic governance breakdowns from 2019–2024, including:

- Lack of oversight
- Absence of formal reporting, testing, or escalation protocols
- Organizational silos
- Infrastructure deterioration
- Procurement delays

There is now a custody improvement group chaired by the Assistant Commissioner of Police which has oversight of all custody issues, risks and improvement plans. This enables key issues to be addressed at executive level within the service.

- **Recurrence of attempted self-harm incidents**

As mentioned in the Summary of Incidents above, there were several incidents reported to the OMB by CIDC managers and members of the public which raised the concerns that ultimately led to the commencement of this investigation. The persons involved are identified as Individual #1, Individual #2 etc. to protect their identities.

It was discovered that RCIPS officers documented most of the incidents in an "incident summary" format which, in each case, gave varying levels of detail as to what had occurred. The level of detail differed widely and, in most cases, the CIDC Inspector noted that no learning or additional training resulted from the incidents after the fact, which is obviously a concern. OMB will review some of the matters below, excluding the case of Individual #1 which was already the subject of an investigation under the Police (Complaints by the Public) Act. In addition, there were details of multiple incidents provided to the OMB which were reviewed as part of this investigation.

Individual #3 -

This detainee was in his cell and was being given his medication by custody staff when he grabbed the packet through the cell hatch and ingested the contents (antidepressants). Individual #3 was taken to HSA and treated. This incident was reported to the OMB separately, but no formal complaint was ever made.

The following questions were raised by the OMB in relation to this incident (**all RCIPS responses bolded**):

Questions

1. How was this policy complied with in this situation? Did the officers have approval to provide this medication to the detainee? ***"Yes, custody staff do (have approval) based on the prescription instructions. However, there was a lapse in judgment by custody staff in giving the detainee the entire medication."***

2. What were any learning/training provisions made as a result of this incident? ***"Only to give the prescribed amount as stated on the prescription to the person detained."***

3. Should officers carry a full bottle of prescription medication into the cell area? ***"No"***

4. The policy makes note of safe storage and handling of medication. Does the CIDC have such a policy (which is not noted in the custody policy)? ***"No."***

The response to question 4 needs further explanation, as the RCIPS Guidance on Detention and Handling of Persons in Police Custody policy does contain instructions on medication in section 6.3.4. It states as follows:

"Where it is known that a detainee requires medication, the custody officer is responsible for:

- *The safekeeping of the medication, which should be held in a locked receptacle to prevent unauthorised access*
- *Appropriate storage of medication, e.g., some insulin and other drugs must be stored in a fridge*
- *Providing the detainee with the opportunity to self-administer the medication at the prescribed intervals*
- *Ensuring that the correct medication is available to the detainee and at the right dosage*
- *Recording information in the custody record (including a record of all consultations with healthcare professionals)"* [2]

The OMB later learned that the Guidance on Detention policy is a separate document to the RCIPS Custody of Prisoners policy of 2018. The CIDC inspector explained it as follows:

"They are two separate document(s). A policy is a definitive statement of position on an issue concerning the organization's effective operation. The Guidance on Detention is a detailed, step-by-step description of the activities necessary to fulfill the policy. As it stands, the policy is the governing document."

What OMB believes the inspector describes above is the difference between a policy and a procedure. In any case, the CIDC officer(s) involved with Individual #3 above should not have carried a full bottle of prescription medication into the cell block area in accordance with point 4 of the procedure guidance above.

Individual #4 –
A check of this prisoner's cell was conducted at a given time in the afternoon and the AC noted the individual had made a noose with his bedsheets and anchored it to the toilet enclosure. The sheets were unentangled and removed from the cell.

No visible injuries were observed. There were no indications on the adverse report form regarding what occurred following this incident.

[2] RCIPS Guidance on Detention and Handling of Persons in Police Custody

The OMB sought clarification on this incident as well:

Question

1. *Can you provide a summary of what CIDC officers did in response to this incident?* ***The form (in OMB's possession) is the report that was provided. The JMS log does not capture what they did so I am unable to provide that bit of information.***

Page 53, section 9.2.1 of the Custody of Prisoners policy (2018) defines an adverse incident in the CIDC and sets out what steps are to be taken following such an incident:

Section 9.2.1 – *"An adverse incident is one which, if allowed to continue to its ultimate conclusion, would have resulted in the death, serious injury or harm to any person* [3]

Section 9.4e of the same policy requires an adverse incident report to be submitted to the CIDC supervisor prior to the end of the shift.

In the case of Individual #4, this was done. However, the form was quite sparse in details and the Jail Information Management System log was also of no assistance to the CIDC Inspector. He was unable to determine what officers did in response and did not indicate any learning resulting from this incident.

Other incidents –
Other instances of potential self-harm by CIDC prisoners were reported to OMB during this investigation. OMB will include limited details on the incidents in this report, due to the potential to identify the individuals involved. However, both incidents, one from 2025 and one from 2024, involved detainees attempting to use articles of clothing to inflict self-harm within their CIDC cells.

First incident –

The detainee displayed aggressive and abusive behaviour upon being booked into CIDC and struggled with officers who searched her and removed her belongings.

Once her personal property was recovered, the detainee was escorted to a cell. Shortly after the cell door was closed, the attending AC was notified that the detainee was using the jacket she wore to wrap around her neck and attempt to hang herself. The AC observed this through the cell door and

[3] RCIPS Custody of Prisoners Policy (2018)

notified other officers who went into the cell and removed the jacket. The individual was checked every 15 minutes after that, as she was considered a self-harm risk.

*Questions from OMB (**all RCIPS responses bolded**):*

1. (Redacted for security purposes)

*2. Why was the jacket not considered a ligature risk by officers? **Based on CIDC Sergeant initial assessment it was not considered , as the individual did not indicate the desire to self-harm initially.***

*3. What learning/training occurred following this incident? **No training occurred, as another CIDC Sergeant was filling in and was advised of the Adverse Incident Form and protocol in such a situation. Training for staff is currently being put together by (the RCIPS training unit)***

4. Is clothing identified in the RCIPS Custody Policy (2018) as a ligature risk?

Custody of Prisoners policy section 2.14. Clothing

2.14.1. Any item of clothing can be used as a ligature. Belts, ties, cords and shoelaces are obvious and more readily available as ligatures. The decision to remove these items should be made after conducting the Risk Assessment and the Custody Officer must balance any risk with the need to treat the prisoner with dignity.
2.14.2. If a prisoner is believed to be at risk of suicide or self-harm, the seizure and exchange of clothing may not remove the risk but may increase the distress caused to the individual concerned, and therefore increase the risk of the prisoner self-harming. Leaving someone in their own clothing may help to normalize their situation. Constant observation or within close proximity may be a more appropriate control measure in these circumstances.[4]

Second incident –

According to the RCIPS Adverse Incident report, the prisoner attempted to take his own life by using a string from his shorts, along with his shirt and bedspread. He secured his tied-up clothing and bedspread to a screw in the bathroom area and tied it around his neck. The screws are used for the toilet tissue holder in the bathroom area.

[4] RCIPS Custody of Prisoners Police (2018)

ACs responded by cutting the string with scissors. The detainee had no visible injuries. He was taken to hospital.

Questions from OMB:

1. Was an assessment conducted on the prisoner prior to booking including questions about his mental state and suicide risk? ***Yes. Based on CIDC Sergeant initial assessment, he was not considered a high risk to suicide.***

2. Was any review of the incident done internally for learning/training purposes? ***No training, Action - cells were checked for screws protruding and those found were removed by Public works.***

In further response to questions about the second incident, the CIDC inspector made some additional notes:

"Lessons, should however be learned from this incident, which would include the following:

- ***Proper inspection of the facility prior to take over.***
- ***Proper search of inmates clothing, loose clothing articles, such as belts and pants, blouse or shorts strings. Anything that could potentially cause self-induced harm to the detainee.***
- ***Once he is returned from the hospital please add, "After consideration of the incident, the inmates was transferred to the Mental Health Ward, Health Services Authority for an assessment."***

Prisoner evaluations

The RCIPS Custody or Prisoners policy, as well as the Guidance on Detention document, provide detailed procedures on prisoner assessment and self-harm risks associated with those in custody. In both of the 'other incidents" noted above, the CIDC Sergeant on duty did perform a risk assessment on the individuals involved. However, there are obvious limitations to this process, including in some cases a lack of training and appropriate staffing, language barriers and instances where routine check-ups on detainees were simply not being done, or if they were done, they were not recorded. These matters will be addressed later in this report. The individual incidents of attempted self-harm must be looked at in conjunction with other issues the CIDC is facing in these areas.

Findings:

1. There are numerous incidents of attempted self-harm occurring at CIDC
2. RCIPS officers may not be appropriately trained in all cases to assess at-risk persons or respond to the incidents that occur
3. Adverse incidents are recorded, but details provided in each separate event vary widely and, in some cases, are largely unhelpful in determining what occurred, or identifying potential learning opportunities.

Recommendations:

As this issue was not one raised in the Interim Report, the Ombudsman has made additional recommendations:

1.RCIPS should review self-harm/injury incidents occurring within the past three years at CIDC to identify additional areas of training for officers , including initial detainee assessments and psychological evaluations
2.A report of the review referenced in point #1 should be provided to the Ombudsman within six months of the submission of this report to the Commissioner of Police.

Issue 2: Record keeping/Intake procedures at the CIDC

• Security doors left ajar in multiple locations

Internal security doors within the CIDC were routinely left ajar and not pushed to lock. This was observed throughout all nine visits by OMB personnel and presents a significant security vulnerability.

On one occasion, an OMB investigator was able to walk unimpeded from the front lobby directly to the Sergeant's desk before being redirected. In another instance, an investigator walked freely from Delta Pod to Echo Pod - areas housing prisoner cells - through two internal security doors equipped with locking mechanisms that had been left unsecured.

For clarity, the CIDC has six external security doors:

- The visitor entrance at the front of the facility.

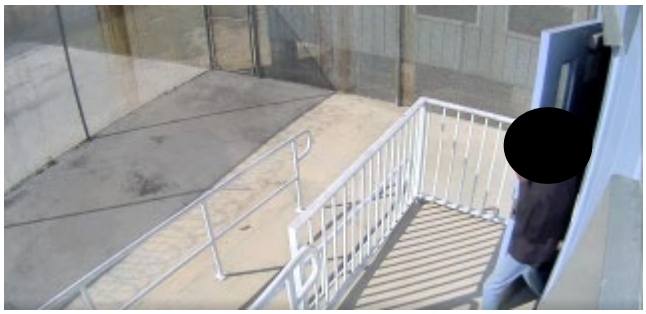
- The detainee booking entrance
- Two cell block entrances, one at Echo Pod and one at Delta Pod leading to a small, fenced 'break area" where detainees are allowed to go under supervision.
- A side entrance adjacent to the smaller modular building housing the Inspector's office.
- A rear entrance

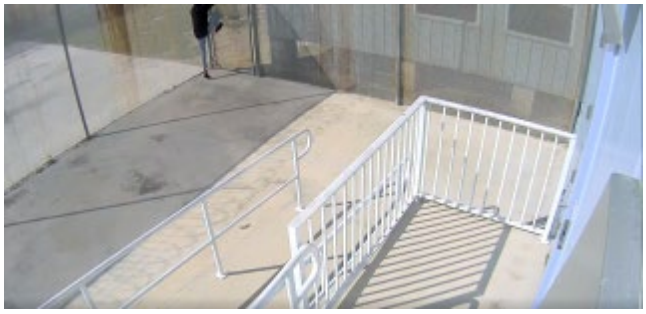
During our June visits, OMB did not observe any of these external security doors being left ajar. The issue appeared confined to the internal security doors.

However, OMB has recovered CCTV footage showing that an attempted escape from the CIDC on 20 January 2022 may have been facilitated by the practice of leaving security doors ajar. OMB has received further details from RCIPS on this matter in the form of two reports completed in relation to the same incident.

Examples of interior doors left ajar:

Still images of the attempted escape incident on 20 January 2022:

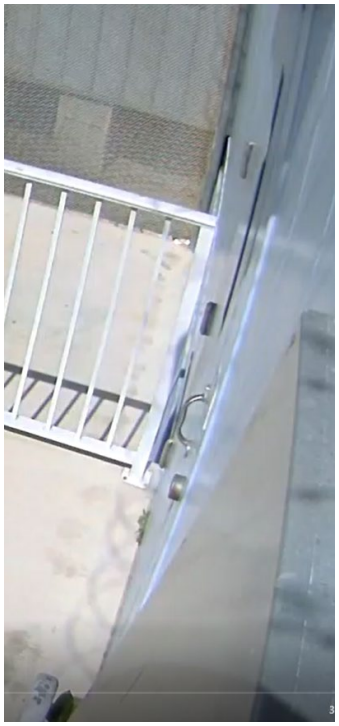




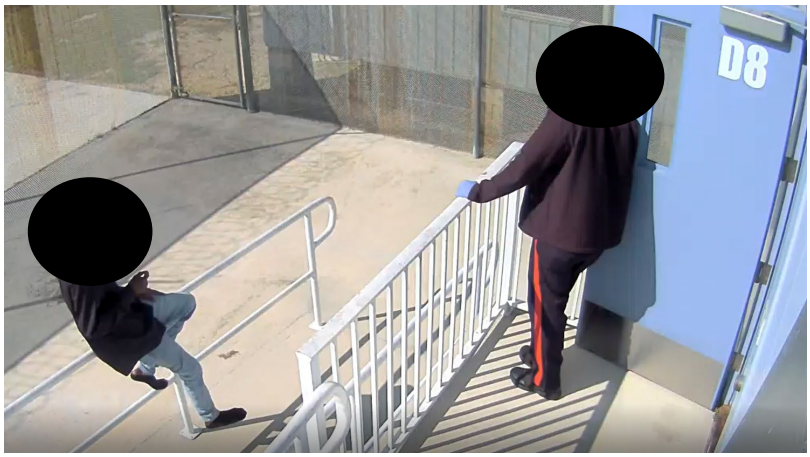
January 2022 Attempted Escape

The OMB reviewed footage from three different cameras operating inside and outside the CIDC to determine what occurred. One of the cameras is trained on the Delta wing (D-wing) exit door outside the facility. The second camera is inside the facility, providing a view of the entire D-wing interior with the doors of each individual cell visible. The third camera is trained on the police custody office area pointed in the opposite direction from the D-block exit door. For the purposes of this report, we will only use still images of footage from the outdoor camera.

At the beginning of the footage, around 1pm in the afternoon, the camera shows the exit door to D-wing is closed:

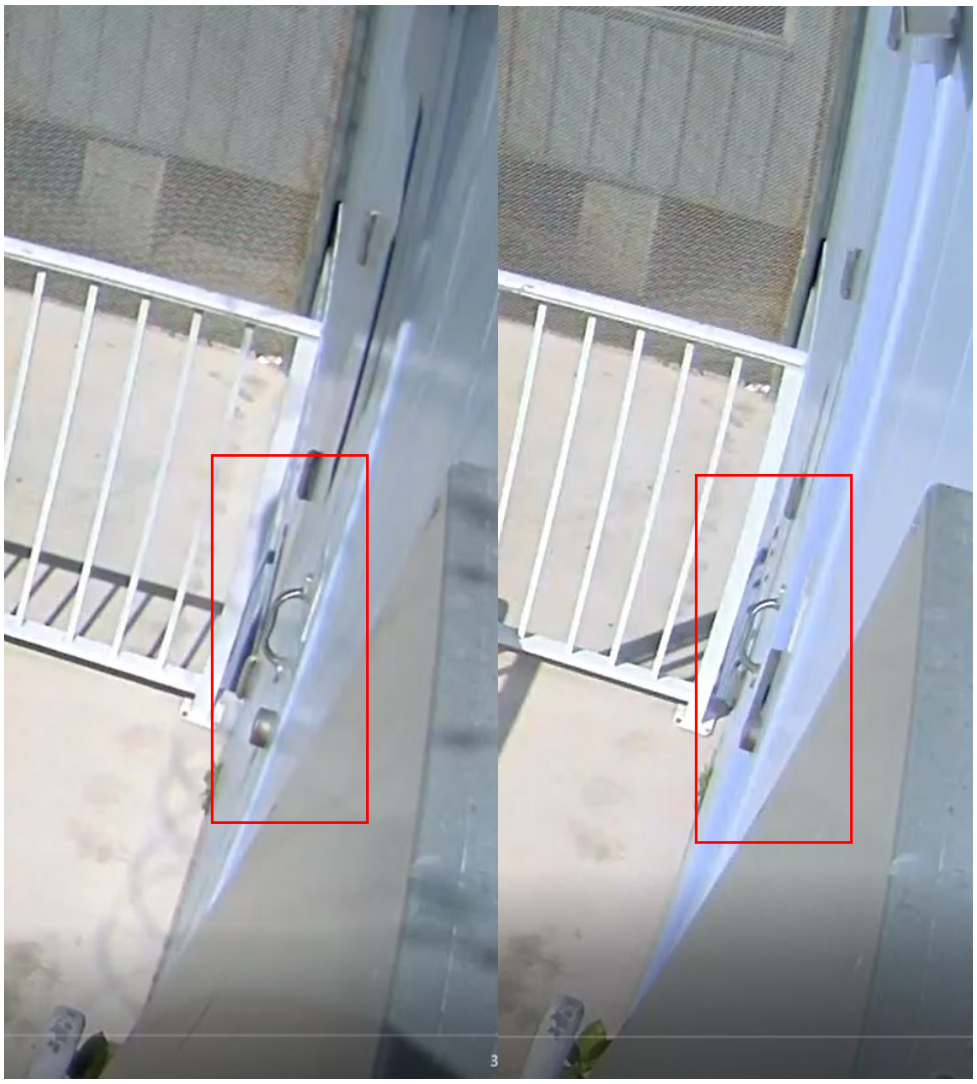


At approximately 1:41 on the video timer (approximately 2:41p that afternoon), the prisoner can be seen outside the D-wing exit door smoking a cigarette under the supervision of a RCIPS officer:



The pair then go back inside and the door is left in the following state:

By comparing between the door when it was secured and when it was left following the smoke break, it is easy to see that the door is no longer secured. The second still frame below was taken at 1:41:49 on the CCTV camera timer:



At 1:57:50 on the CCTV camera timer, roughly 2:58pm, the detainee leaves from the ajar exit door and proceeds to climb over the barbed wire security fence as noted in the earlier images, injuring himself in the process.

The RCIPS internal investigation of the incident provides a helpful timeline of events which indicates that, at approximately 3pm, just minutes after the detainee exited, an AC noted the exterior door to D-wing was open. Following a brief search at around 3:05p-3:10p blood from the detainee was observed near a trailer on the CIDC compound and that the detainee had hidden under the trailer. He was persuaded to surrender and transported to hospital for treatment. As he was found still on the CIDC property, RCIPS did not consider this an escape, but an attempted escape.

Causal factors listed in the internal investigation report included a potential door malfunction, as well as human error, noting the AC may not have verified “full lock engagement on D8 (the exit

door) before departing". In addition, it was noted that the detainee had exhibited "opportunistic behaviour" and had repeatedly attempted to "test staff availability and create openings".

Mitigation measures were taken as a result of the incident, and it was noted in the internal report that a full facility audit, including repair of all door-related electrical/mechanical issues, was needed in the future.

Nonetheless, OMB learned that RCIPS supervisors at CIDC are aware that many of the interior security doors are often left ajar. This is due to officers becoming annoyed with the sounds of the doors being released from their locking mechanism, producing a jarringly loud noise. It is also because officers would otherwise have to interrupt CIDC Sergeants to provide them with access for multiple entries and exits. The officers considered this to be a hassle, especially when the CIDC is short-staffed and duty Sergeants are handling both prisoner intake and police bail renewals, often at the same time.

The CIDC Inspector indicated that the RCIPS is considering the use of FOB key entries, which would be a cost, but may be a more efficient, more secure system.

Key access

The CIDC Inspector also identified an additional security concern of equal urgency and importance. At the time of this investigation, there was no external means of access to the facility in the event that the duty Sergeant or another officer is unable to activate the automatic door release system. OMB understands this potential security risk has been addressed (see RCIPS recommendations update below).

The only physical key to the facility in the Cayman Islands, at the time of this investigation, was at the CIDC Sergeant's desk. This arrangement presented a significant operational risk, as it could result in a scenario where, should officers on duty inside lose control of the facility, external personnel would be unable to enter and provide assistance.

The CIDC Inspector advised of efforts to get a copy of the key made, but stated that it cannot be done in Cayman. Apparently, a copy of the key can only be made by the manufacturer of the CIDC building, situated in the United States.

Findings:

1. Internal security doors at the facility are routinely being left ajar, which is a significant security risk

2. There is some evidence to suggest that external doors have been left ajar, inadvertently facilitating an escape from the CIDC in 2022
3. There is no way for external RCIPS officers to enter the CIDC building to provide assistance if internal officers ever lose control of the facility

These findings represent a major and urgent security risk to RCIPS/CIDC detainees as well as a potential risk to members of the public. The following actions have been taken by the RCIPS since the issuance of the OMB interim report in September 2025:

RCIPS response to OMB recommendations:

Recommendations 5–6 – Security Door Protocols & Escape Risk Management

- *Reinforce internal policy requiring all security doors to remain locked when not in active use.*
- *Install automatic door-closing mechanisms or alarms for internal doors.*
- *Consider the procurement of FOBs or other secure means of staff access.*
- *Conduct a full review of the 2022 escape incident and provide a report to the Ombudsman within 3 months of the date hereof. The findings should also be integrated into revised security procedures.*
- *Implement regular security audits to ensure compliance. A system of daily documented checks at each changeover of Custody Sergeant is now completed.*

Status: In Progress / Completed

- Custody Sergeants continue active supervision ensuring internal doors remain secured when not in use. This is now part of documented daily checks.
- Alarm installation for internal doors and panic strips were due for completion by 19th December 2025**.**
- Locks serviced; doors D2 & D6 scheduled for removal and repair to ensure proper closure.
- Review of the 2022 escape attempt has been completed and embedded in SOPs.
- Security audits conducted regularly; compliance is overseen by the Custody Inspector and Superintendent and is reported on at the Custody Improvement Group monthly.

Recommendation 7 – Emergency Access Protocol:

- *Procure additional facility keys within one month of the date hereof and securely store at designated RCIPS locations.*
- *Develop an emergency override access system (e.g., secure lockbox or biometric override) for use by authorised external officers.*

- *Include emergency access procedures in CIDC's critical incident response plan.*

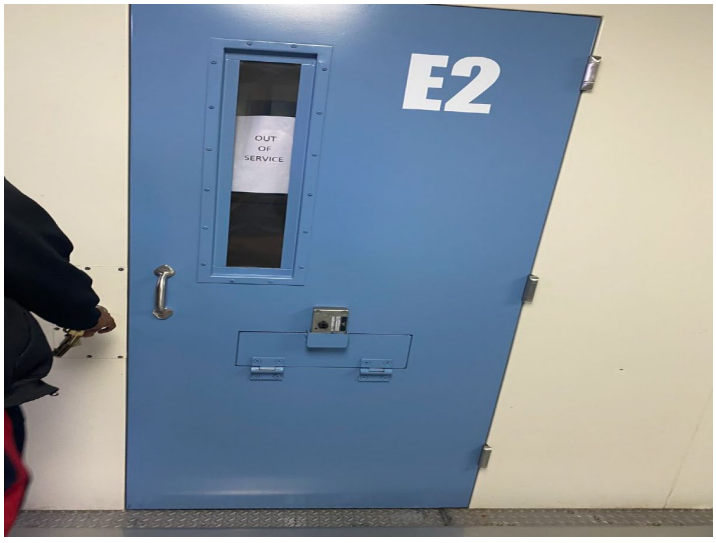
Status: Completed
New Update (4 December 2025):

- Emergency facility keys for (identified doors) are now onsite, delivered, and verified functional.
- Incorrect shipment earlier caused delay; issue resolved with distributor.
- Keys will be held securely under the updated emergency override protocol for authorized personnel, including A99 (shift supervisor).

• Cell inoperable due to overhead light damage

At all times during the nine OMB team visits, cell E-2 on Echo Pod was out of service. This followed an incident in April 2025 where a detainee apparently damaged the overhead light, leaving several screws on the floor.

The following are images of the cell and the damaged light:



At the time of OMB's review, the E-2 cell had been out of service for approximately two months. We noted that officers were not aware of the specific incident, until after the damage occurred.

An email sent on 5 April 2025 appeared to be the first report of the damage to the light:

"Good morning Inspector,
"I reported for duty today and it was brought to my attention by (another AC) that the light in Cell #E2 was damaged and four of the screws removed. Two of the screws were found on the ground in the cell and part of the glass broken. There was no indication from the shift going off duty as to the damage."

The police Superintendent with responsibility for the CIDC noted that this report indicated no one had searched the cells when reporting to duty or at the conclusion of duty. The Superintendent ordered that no further detainees be placed in the cell, that an out of service notice should be placed on the cell door (this was done) and that the light would be replaced "by Monday".

As of late June 2025, the light had not been replaced. The CIDC Inspector noted there may have been some trouble sourcing a replacement part for the light.

The damage to the light in cell E-2 raised another issue OMB noted which is a lack of CCTV coverage within CIDC. Currently, there are four cells, out of a total of 12, that are monitored by CCTV. Those are for detainees with specific issues which may require monitoring, as determined by the CIDC. The damaged cell is not one with CCTV capability.

The CIDC Inspector is of the view that no more cells require CCTV installation at present. However, he has advocated for the placement of another two in the hallway of the CIDC main area, as there are "blind spots" around a corner where the entrance to the Inspector's office building is located. Also, the CIDC Sergeant cannot view the security door, located just after the main entrance, on CCTV.

Findings:

1. Damage to a CIDC cell has gone unrepaired for more than two months, leaving it out of service
2. Police appear to be largely unaware of how this damage occurred
3. There are "blind spots" within the CIDC which cause a potential risk for both police officers, detainees and visitors.

The RCIPS has substantively responded to the recommendations made in the interim report.

RCIPS response to OMB recommendations:

Recommendations 8–9 – Improve Facility Maintenance & Incident Reporting

- *Establish a maintenance response timeline for damaged infrastructure, with escalation procedures for delays exceeding 14 days.*
- *Implement a formal incident reporting and investigation process for all facility damage, including photographic documentation and staff interviews.*

Status: Completed

- Daily maintenance check sheets active; defects escalated immediately. These are completed by all Custody Sergeants at the commencement of their shift.
- S.A.F.E.R. (Internal Safety Review Form) implemented for:
  - ✓ Documentation
  - ✓ Photo evidence
  - ✓ Staff interviews
  - ✓ Investigation

- Escalation triggers at 24hrs now standard. Any defects are reported to the estate management team to escalate repairs. Oversight is managed by Custody Inspector and Superintendent. When a safety defect is found, the necessary operational safety measures (e.g. placing a cell out of use) are actioned by the Custody Sergeant. If health and safety matters are not addressed they are escalated for review to the Assistant Commissioner.

Recommendation 10 – Eliminate Surveillance Blind Spots

- *Conduct a full security assessment to identify and map all blind spots within the facility.*
- *Install additional surveillance cameras or mirrors in identified areas.*
- *Review camera placement annually and update as needed.*

Status: In Progress

A full security review has been completed to identify all blind spots in the Custody Suite with new CCTV cameras being installed to address gaps.

- New CCTV installations have been completed now providing full coverage in all cells and internal and external areas. One final camera remains to be fitted by 19th December 2025 which will cover the one remaining blind spot on the corridor between the staff rest room and interview room. All cameras are recording 24 hours per day.
- Expected completion: 19th December 2025.

- **Detainee welfare checks**

As part of this investigation, the OMB obtained a random sample of CIDC booking logs for detainees between January 2025 and June 2025. These were selected randomly by the Sergeants on duty. We have reviewed several files below, using the prisoner's booking number to protect their identity.

- Inmate Log 33155: One entry at 0818 hours stating "moved from old cell location". There is no further entry for the entire day until 1900 hours, nearly 11 hours later, which states "handover prisoner to AC (officers on the incoming shift)"
- Inmate Log 33155: There is another entry later the same day at 2210 hours indicating "take over duty from AC with all appears to be in good order." There is not another entry on the log again until 700 the next morning, some 9 hours later.

- Inmate Log 33174: There is an entry at 0701 hours indicating handover of the prisoner at shift change. A second entry is recorded at 1140 stating what the prisoner ate for lunch. A third entry is found at 1710 for his formal charging.
- Inmate Log 32374: There were three entries on the same date at 0810 hours, 1230 hours and 1800 hours, all of which described in detail what the prisoner ate at his three meals for the day. There were no other entries.

There were other entries in which the CIDC ACs attended the prisoners far more frequently.

- Inmate Log 32225: This prisoner was checked a total of seven times between 0701 hrs and 1730 hrs. Recorded entries included welfare checks, a smoke break, a call to his attorney and a meal provision.
- Inmate Log 32502: The prisoner was checked at 0100 hrs and again at 0515 hrs. Officers did not awaken him, but just peered through door window to make sure the prisoner was still breathing.
- Inmate Log 32612: This prisoner log was updated at 1215 hrs to note a call was made on his behalf. The next contact is at 1630 hrs for a meal. At 1900 hrs, a shift check and handover are done, and the prisoner is not logged again until 0400 to confirm he is asleep.

The RCIPS Custody of Prisoners policy (2018) sets out the minimum monitoring and observation levels for detainees at the CIDC in section 4.6. The "Level 1" or lowest-risk prisoners are monitored at what the policy refers to as the "minimum acceptable level for all prisoners":

- *Prisoners are checked at least every hour but more frequently where possible*
- *Checks are carried out sensitively in order to cause as little intrusion as possible*
- *If no reasonable foreseeable risk is identified, staff need not wake a sleeping prisoner*
- *If the prisoner is aware staff should engage with the prisoner; e.g. visits and observations, including the prisoner's behaviour/condition, are recorded on the custody record*
- *Any changes in behaviour/condition must be reported to the custody officer immediately.* [5]

The OMB reviewed dozens more inmate logs with similar findings to those above, making it clear that a) these hourly checks are not being done or b) the checks are not being recorded or logged by the officers performing them. Further, the level of detail included on the log, other than in some cases the detailed documentation of what the prisoner ate (which is done in case the person has an unknown food allergy), is quite minimal in most of the entries. There are logs with no record of a

[5] RCIPS Custody of Prisoners Policy (2018)

prisoner being checked or fed for an entire day. In OMB's view, this likely does not mean they were neglected for the entire day; rather, the officer checking the prisoner has simply failed to record the interaction. However, it is impossible to know this for certain.

This is an issue of which the CIDC Inspector is keenly aware. For example, in one inmate log we examined, there was no recorded contact with the inmate between 8am and 7pm of the same day. The CIDC Inspector states it was unlikely the ACs left the prisoner in the cell without feeding him for an entire day. However, he conceded he couldn't be certain because the officers hadn't updated the log. In most of the logs reviewed by OMB, there is no record of prisoners being checked every hour as the Custody of Prisoners Policy requires.

In the CIDC Inspector's view this is a staffing issue. Particularly during the day, the Inspector noted, if officers get too busy, or during a shift handover, they will neglect to put items in a prisoner log: "Because it gets busy and sometimes, they'll forget. When you're short-staffed and the demand is there in the daytime, it's difficult to juggle all the activities".

It is important to bear in mind that, in the first half of 2025, the RCIPS was averaging more than 200 arrests per month and processed approximately 500 police bail applications each month, as noted elsewhere in the report. This is in addition to any prisoners CIDC officers receive on behalf of Customs and Border Control (CBC) and His Majesty's Prison Service (HMPS).

The CIDC Inspector also noted, in accordance with the custody policy, that officers won't wake prisoners up after 10pm and will instead peek through the cell window to see if the prisoner is breathing and sleeping. He notes this should also be recorded in the log. The policy requires high risk prisoners to be checked more frequently and those prisoners will generally be placed in a cell with a CCTV camera.

Findings:

1. CIDC officers are not performing hourly prisoner checks, or not recording them when they do
2. Information contained on the detainee (inmate) logs is often sparse and unhelpful in terms of prisoner care
3. Understaffing and work volumes are preventing CIDC officers, in many cases, from performing these welfare checks as the Custody of Prisoners policy outlines.
4. This issue is a crucial one to resolve, given the number of attempted self-harm incidents occurring at CIDC

Recommendations:

As this issue was not included in the Interim Report, the Ombudsman has made additional recommendations:

1. RCIPS should consider whether another method – such as a prisoner log sheet, posted outside each cell door – could be used by officers and then updated once at the end of one shift, or the beginning of the next.
2. RCIPS should monitor the inmate logs in JMS for quality assurance.
3. OMB will review prisoner logs again in six months, following the submission of this investigation report to the Commissioner of Police.

- **General intake procedures at CIDC**

Booking into the CIDC is usually a two-part process that can take anywhere from 15 minutes to more than an hour, depending on police resources and the cooperation level of detainees. Police officers who have arrested an individual will drive their vehicles through a gate near the entrance to the Echo Wing (E-Wing) cells and bring the detainee in through a side door that leads directly to the booking area.

Typically, OMB observed that prisoners were brought into a holding cell area adjacent to the main booking area where they were sometimes searched or spoken to by officers. They are then booked at the Sergeant's desk, which includes the Sergeant entering their personal details on a booking form, the detainee answering questions about their health and mental state, and being given options to contact an attorney, if they should wish. The detainee is allowed to make a call to an attorney immediately and is allowed to choose from a list of lawyers maintained by the RCIPS. They are not assigned duty counsel.

Following booking, the person is taken to a side room for processing, which includes fingerprinting and, if needed, an intoxilyzer test. One Sergeant advised OMB that they do not allow more than two prisoners at a time in the booking area due to space constraints. The Sergeant noted this limits the number of bookings that can be completed and that at times, patrol officers holding prisoners must wait in their vehicles outside the CIDC with their prisoners until the processing area clears. This is not a good use of patrol officers' time.

The OMB observed a number of booking processes during its visits to the CIDC in June 2025. We will provide a few general descriptions and observations below and relate them to the requirements of the RCIPS Custody of Prisoners policy.

Overnight period of 6-7 June 2025: A DUI suspect was brought into booking and put in a holding cell where he had his handcuffs removed. When released from the holding area, he walked freely into the booking area and was questioned by the Sergeant. A total of four officers came in with the single detainee.

The detainee was informed, as he was a foreign national, he would need to have someone bring his passport to the CIDC or have a Caymanian post a surety for him. Officers assisted the man in trying to find a charger for his phone while the intoxilyzer machine was turned on in the processing area. After questioning by the Sergeant, the man was left in a chair in the booking area and sat down with his head in his hands. At times, there were officers coming in and out of the booking area, but there were times when the man was in the area alone. He was taken into the processing room about 20 minutes later, after the intoxilyzer machine had "warmed up", according to officers.

A second detainee (also suspected DUI) entered with just one officer attending in a traffic uniform. He also was placed in the holding cell where his handcuffs were taken off. While the second detainee was booked in, the first one came out of processing and was placed back in the holding cell for a brief time while officers tried to reach someone by phone who could bring his passport to the CIDC.

The second detainee was read his rights by the duty Sergeant and was asked several questions, which he didn't seem to understand. He stated he did not wish to speak to an attorney, but appeared confused about the waiver the duty Sergeant asked him to sign. The man stumbled about the booking area with a clipboard and pen in hand for several minutes.

About half an hour later, the second detainee was placed in the processing room. The first detainee was released in the pre-dawn hours after an individual arrived at CIDC with his passport.

OMB asked several questions about the procedures above and received the following responses from the CIDC Sergeant on duty:

- The first DUI suspect was brought in by four officers (two per vehicle) from Bodden Town district because the initial arresting officer is not allowed to do the intoxilyzer machine test for the suspect they have detained. In this case, the arresting officer's partner, a

probationary officer, had not received training in how to do these tests, so another unit from Bodden Town had to be called in for a different officer to perform the test.

- Both suspects were left uncuffed in the booking area because it is generally uncomfortable for them to wear the cuffs while sitting in the lobby chairs. Both men were assessed at a low threat risk.
- The newer intoxilyzer machine used at CIDC was out of service for maintenance and the older model required a warm-up period of about 20 minutes. The duty Sergeant stated normally they ask the officers to call ahead so they can fire up the older machine. The delay added about 20-25 minutes to the booking process for the first detainee.

The OMB did not observe either detainee on this evening being searched by CIDC ACs. The RCIPS Custody of Prisoners policy (2018) states the following with regard to searches:

Section 2.11.1 – "Prisoners must be searched on arrest. All prisoners must also be subjected to a more thorough and methodical search on arrival at the custody reception area. This should ensure they are not in possession of any articles which are capable of causing injury to themselves or others…" [6]

The policy then goes on to state the types of searches that should be done and mandates in section 2.11.3 that any search of a prisoner must be done by a prisoner of the same sex. It is also noted in the policy that intimate body searches must be done on an Inspector's authority only and must be done by a suitably qualified officer. The duty Sergeant this night informed OMB that body cavity searches were typically not done at CIDC due to a lack of a proper private area to perform such a search.

Issues with searching CIDC prisoners were raised to the RCIPS in a 2021 report commissioned by the former Commissioner of Police entitled the 'RCIPS Custody Review (2021)'. On page 68, the document states as follows:

Searching and Prisoner Property

The Detention Centre staff conduct the searches of detainees when in Custody. This doesn't necessarily take place as an immediate action upon the arrival of the detainee in Custody, but moreover once a decision has been made to place them in a cell. This brings about several inherent risks, such as failure to locate and secure illicit weapons, drugs or other items of evidential value, as well as placing staff and detainees at risk of injury. [7]

[6] RCIPS Custody of Prisoners policy (2018)
[7] RCIPS Custody Review (2021)

The RCIPS Custody Review report recommendations, made to the RCIPS at that time, are addressed later in this investigation report.

In addition, OMB noted that metal detector wands were used to search detainees at different points in the booking procedure on various nights. Two prisoners were wanded prior to entering their cells, another prisoner was wanded in the police custody office area, and a third was wanded shortly after entering the booking area.

The duty Sergeant stated there is no set policy concerning metal detector searches for detainees. The Sergeant stated that detainees are typically searched three times; the first will be done by the arresting officer, the second upon placement into the CIDC holding cell and a third search will be done prior to them being placed in a CIDC cell. Metal detector wands can be used at any point in this process, the Sergeant stated.

Evening of 19 June 2025 – At this time two detainees were brought into the CIDC booking area simultaneously. The first was a Customs and Border Control (CBC) prisoner who was due to be deported from Cayman the following day. The detainee was brought in without handcuffs and left unaccompanied at the booking desk after the CBC officer departed the CIDC.

At the same time, another detainee had returned from a hospital visit. The detainee was observed by OMB being loud, aggressive and not complying with officers' instructions – shouting, swearing and issuing threats. The second detainee was not placed in handcuffs at any time and was escorted to the police custody office through the security doors by a single staff officer and was not placed in a cell. During this time, the detainee was able grab a pen which he began holding while making threats to custody staff. Four to five RCIPS officers responded to remove the pen from the detainee, who was still not placed in restraints even after this incident occurred.

The RCIPS Custody of Prisoners policy states the following in relation to violent or potentially violent detainees:

Section 2.3.1 – Officers transporting a violent person to the custody office should inform custody staff of their impending arrival. Persons should be cleared from the custody reception area to prevent them being involved with or injured by the prisoner." [8]

It was not known to OMB whether the second prisoner brought in from the hospital visit on this date was ever thoroughly searched. However, CIDC officers were dealing with this second prisoner while the first man, awaiting deportation, was still being booked in – which would appear to be in

[8] RCIPS Custody of Prisoners policy (2018)

violation of the policy above. It also may have created a dangerous situation for CIDC officers given the ongoing situation with the internal security doors being left ajar.

Morning of 16 June 2025: OMB observed during this visit that a total of five civilian cleaning staff arrived at CIDC between 8.30-9am, all at different times.

The cleaners were given access to the facility to the extent needed to perform their tasks, however the OMB observer noted they were all in different places at different times and it would have been impossible for CIDC officers to keep track of them given the workloads officers were processing.

This was a concern noted by OMB investigators at various times who observed:

- The drawer holding passports taken for police bail conditions was not locked and could be opened by anyone with access to the custody office. One CIDC officer estimated there were 900 passports contained in the filing cabinet.
- On one day when OMB investigators arrived at CIDC for a briefing by the Inspector, papers containing charging information for dozens of detainees were left out on the ledge of the custody office and could have been examined/removed by anyone with access to that area.
- A total of 10 persons were waiting in the visitors' area at the time the OMB investigator left the CIDC on 16 June 2025. Given that one of the OMB investigators was able to walk through security doors which were left ajar from the visitor's area to the Sergeant's desk in the booking area, this is also a security concern.

Findings:

1. Policy requirements that each detainee be searched upon entry to the CIDC were not complied with in all cases OMB observed.
2. Metal detector wand scans were done sporadically, if at all. There is no policy requiring the scans for detainees.
3. Detainees were sometimes left unsupervised in the booking area during the late-night hours. The desk Sergeant was typically in attendance but would be unable to react immediately to anything in the booking area floor as they are behind a secure, walled-in desk.
4. A situation with a potentially abusive, violent detainee was allowed to escalate, requiring the intervention of 4-5 officers to remove a pen from his hands.
5. Poor security of personal documents was observed in some instances.

Recommendations:

As these findings were not included in the Interim Report, the Ombudsman has made additional recommendations:

1. The RCIPS Custody of Prisoners policy regarding searches should be strictly enforced and a reminder on its requirement sent to all personnel at CIDC
2. A policy should be created for the use of metal detector wands, ideally to wand all detainees who come in at least once
3. Clarify current policy regarding handcuffing and supervision of detainees while they are on the booking area floor. Please send policy updates to the Ombudsman.
4. The Ombudsman will consider whether a review of document security at CIDC by OMB's Information Rights Team is warranted

- **Detainee interviews/attorney consultations**

One of the important law enforcement uses of the CIDC is to assist investigating officers in conducting suspect interviews. There are currently two rooms at CIDC used for detainee interviews. A third room located closer to the entrance and visitor waiting area is used for attorney-client discussions.

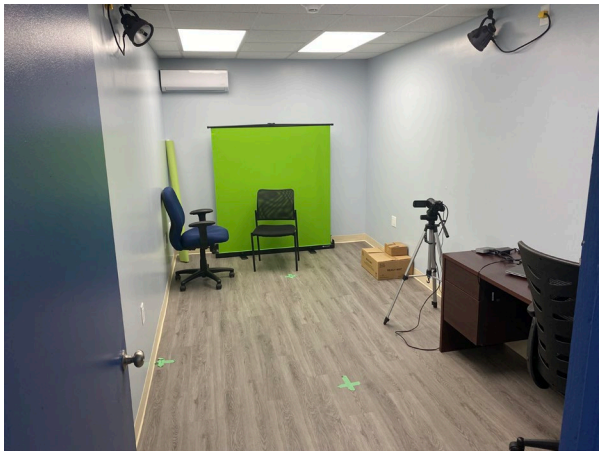
One of the interview rooms can also be used as a courtroom link, if certain testimony or court appearances need to be obtained from the CIDC, for whatever reason. However, when that room is in use for court proceedings, it leaves the CIDC with just one room in which to conduct suspect interviews.

In addition to reduced availability of interview rooms is the unsuitability of the attorney-client discussion room, which attorneys raised as a concern with OMB. The room is very small and hardly able to fit two people. If the door is left open, other individuals standing in the hallway or even the visitor waiting area may be able to hear ongoing discussions.

Photo of attorney-client consult room:

With respect to the interview room availability, OMB noted that there are two other large and mostly empty rooms in the modular extension located next to Delta Wing which can be reached by exiting the main CIDC building and taking the walkway over toward the Inspector's office. One of the rooms is currently used for storage; the second has technology available to conduct photo lineups for prisoners which has not been used on a regular basis for the past few years.

Photos of the two mostly unused additional spaces



The CIDC Inspector agrees the current arrangements don't facilitate the extent of privacy that is required for either attorney-client discussions or for police interviews. Also, the CIDC can be quite noisy at busy times of day which filters into the interview rooms and the sounds can bleed into interview recordings.

During OMB visits, there were two instances where prisoners who were clearly communicating with their attorneys could be heard speaking on the phone. In one from the overnight period of June 7-8, a prisoner was sitting in the consultation room with the door open and his conversation could clearly be heard. In another incident, a prisoner was walking around in the hallway adjacent to the main lobby speaking on the telephone. There was no privacy for either of these conversations, a situation which the CIDC Inspector stated is up to the duty Sergeants to manage, based on the current capacity and usage of the facility.

The current list of available attorneys is held at the CIDC Sergeant's desk, but it is up to the defence bar members themselves to supply the prison with current contact details. The previous on-call rota system for attorneys was dropped some time ago due to concerns about fairness and efficiency, according to the CIDC Inspector.

Findings:

1. It is highly likely that both attorney-client discussions and suspect interviews conducted at CIDC cannot be conducted confidentially, simply due to the size and capacity issues at the facility.
2. There are two large rooms within the CIDC that are not in current use that could presumably be used to conduct interviews or attorney-client meetings.

Recommendations:

As this issue was not raised in the Interim Report, the Ombudsman has included an additional recommendation:

1.The OMB recommends the RCIPS consider using the two larger rooms not currently in use for interviews and requests a response within 30 days of the submission of this report to the Commissioner of Police as to whether this is possible.

Issue 3: Staffing/training issues at CIDC

• Current staffing levels for Auxiliary Constables and CIDC Sergeants

During OMB's nine site visits, the typical staff complement included one Sergeant and either three PC/ACs or two ACs. The CIDC Inspector had previously stated that the ideal number of PC/ACs

available on each CIDC shift should be four. This number was never observed during any of our visits.

Staffing is a complex problem at the CIDC, given the volume of work the facility is handling daily. The RCIPS averaged more than 200 arrests per month in the first half of 2025 and processed police bail for approximately 500 people per month. In addition, from January through early June, the facility held a total of 46 Customs and Border Control (CBC) detainees for more than 24 hours and an additional 15 detainees from His Majesty's Prison Northward, often for many days at a time.

OMB noted the strain on staff in that at least two CIDC Sergeants worked for 1.5 to 2.5 hours beyond their shifts to process arrest paperwork. This is after a 12-hour shift and, importantly, often returning the next day for another 12-hour shift. During busy shifts, particularly during the day, officers are often unable to take their 1.5 hour statutory break. The CIDC Inspector states this is a common occurrence and puts their health at risk. There were many other health-related issues, including mental health, involving the duty of care owed to employees, of which OMB was made aware and has reported to the Commissioner of Police.

Several CIDC Sergeants, as well as the Inspector, have recommended that the RCIPS consider employing two Sergeants either at the same time, or on staggered shifts to assist with the processing volume resulting from police bails, incoming and detained prisoners.

This suggestion presents another problem: more Sergeants, as well as ACs, would have to be trained in custody work, including data entry training on the Jail Management System (JMS). Currently, when officers from other units are brought in to assist with CIDC staffing, the vast majority will never have received custody training. The OMB was made aware that some police Sergeants were put in that position without having worked in custody previously and this was confirmed to OMB by the CIDC Inspector as well.

In addition to these concerns, each 12-hour shift at the CIDC is supposed to have one female officer on staff. OMB noted this was the case on only two of our nine visits. The CIDC Inspector stated that this was largely a problem with recruitment, which has been an issue throughout the RCIPS. He stated that during a recent recruitment drive for five new ACs, including a new female officer, two of the new hires – including the female – were assigned to street patrol, even though the recruitment was specifically for Auxiliary Constables who would typically staff the CIDC, courts and the Government Administration Building.

Findings:

1. The CIDC is not meeting its own recommended minimum staffing levels on a regular basis

2. The CIDC is not employing female ACs on a regular basis due to difficulty in recruiting and the ACs being deployed elsewhere within the RCIPS
3. Officers are routinely working over normal shift time to complete paperwork
4. CIDC Sergeants, in particular, may be at risk from overwork and/or stress
5. Many ACs have been working at CIDC longer than is recommended (two years at a time)

RCIPS response to OMB recommendations:

Recommendation 11 – Address Chronic Understaffing

- *Conduct a staffing needs analysis and submit a formal request for increased personnel based on operational demand.*
- *Develop a staffing contingency plan, including cross-training and temporary reassignments from other RCIPS units.*

A staffing needs analysis report has been completed (this report was provided to OMB)**.** The proposed staffing model including Police Officer v Auxiliary Constable mix will remain under review and is subject to operational demands on the service. The summary of the staffing needs analysis is detailed below: Potentially if the trial with the placement of a health care professional in custody (addressed in recommendation #2 response above) is positive there will be an opportunity to consider employing a health care professional in addition to the below staffing proposals.

Role	**Policy Requirement**	**Current Staff (2025)**	**Shortfall**	**Proposed 2026 Staffing**
Sergeants	6	5	-1	6 *(leave / coverage)*
Auxiliary Constables (ACs)	22	11	-11	22 *(to allow full coverage & leave)*
Female ACs	Minimum 1 per shift	Inconsistent	-3	6–8 *(rotation across shifts)*
Support/Admin Staff	1–2	0	-2	2 *(data entry, case mgmt)*

Demand Drivers Justifying Staffing Increases

Indicator	**2024–2025 Findings**	**Impact**

Arrests	**~2,359 (2024), ~2,448 projected for 2025**	**↑ Detainee supervision & processing**
Bails	**Monthly average ↑ 27% in 2025**	**↑ Paperwork & court coordination**
Detainees Held >24 hrs	**341 in 6 months**	**↑ Staff coverage for overnight duties (include CBC arrest)**
Hospital Transfers	**16 (Jan–Sept 2025)**	**↑ Need for escorts / external trips**
Ombudsman Report	**Deficiencies in supervision, training, gender balance, health**	**Legal & safety risks if unaddressed**

Status: Pending

- Budget for 2026 approved; however, recruitment begins in 2026. Auxiliary Constable (AC) recruitment will be key to fill the identified shortfall of eleven with specific focus on attracting females to the role. This may prove to be challenging to attract persons to this demanding role. A specific campaign for AC recruitment will commence January 2026
- Two staff became Master Trainers in custody procedure on 29 Nov 2025. This enables expertise and regular training to be delivered across custody staff.
- TDU (RCIPS Training and Development Unit) developing training curriculum; scheduled completion 31 Dec 2025. This training curriculum will be delivered to newly promoted Sergeants and existing custody staff. The staff rotation plan will require new Custody Sergeants to be trained. The Custody Team have reached out the RCIPS twinned force – The City of London Police and are actively sharing best practice and training packages for mutual learning.

Recommendation 12 – Improve Gender Representation Among ACs

- *Prioritise the recruitment and assignment of female Auxiliary Constables to CIDC to ensure gender balance and compliance with best practices in detainee management.*
- *Review current deployment policies to ensure equitable distribution of female officers across units.*

Status: Pending

- This is linked to the recruitment action above. The AC recruitment campaign will specifically aim to attract capable persons to the role, with a specific focus on attracting female applicants. Updates on progress will be reported on in 2026.

Recommendations 13–14 – Mitigate Overwork, Stress & Introduce Wellness Support

- *Monitor officer workloads and implement shift caps and shift staggering to reduce the need for Sergeants to work beyond the normal workday.*
- *Introduce wellness and mental health support services for CIDC staff, with particular attention to Sergeants and supervisory personnel.*

Status: In Progress

- This action is closely linked to the recruitment action and plan detailed above. The HQ directive as detailed at appendix I places responsibility for ensuring breaks with both the Custody Inspector and Duty Inspector when they can be facilitated.
- Wellness and mental health support is now a service wide initiative with a range of wellness initiatives being rolled out across the service.
- Staff continue to work extended hours until promotions & recruitment take effect in 2026. However, this is being closely monitored by the Custody Inspector and Custody Superintendent. The staffing and wellbeing issues are a standing agenda item at the Custody Improvement Group chaired by the Assistant Commissioner.

Recommendations 15 & 17 – Limit Long-Term Assignments & Transition Planning

- *Enforce the recommended two-year rotation policy for ACs assigned to CIDC.*
- *Develop a transition plan for long-serving ACs, including reassignment opportunities and support for reintegration into other units.*

Status: Pending

- Rotation policy cannot be implemented in full until the recruitment campaign and onboarding is completed. Four ACs have been conditionally offered roles for the 2nd February 2026 intake. ACs however are required in a range of roles for example at court, Governors House and process department. When the four ACs graduate in March there will be limited opportunity for some rotation across roles.
- Transition planning for long-serving ACs postponed to 2026 pending promotions and reassignment capabilities.

• Training availability

In addition to the general lack of experience within the RCIPS in custody policing, it was accepted that internal training had fallen off in recent years. Some of the ACs with whom OMB spoke indicated they would like to receive more training in certain aspects of the job.

The OMB reviewed training records for 10 of the ACs, PCs and Sergeants currently working at the CIDC as part of this investigation - more than 60% of the currently assigned staff. The records went as far back as 2011-2012 for some officers and showed a wide array of training including courses on PEACE-model interviewing, CCTV/number plate reading, police law, radar training, investigative interviewing, hate crime awareness and anti-bullying, as well as regular officer safety training (OST), first aid and domestic violence response training.

All RCIPS officers whose files were reviewed had officer safety training completed in 2024. However, only four of the 10 officers reviewed listed JMS-jail management training and one of the four officers who had received the training hadn't taken a refresher course since 2016. One of the regularly assigned CIDC Sergeants did not list this training.

Further, there were different types of custody-related training on the officers' records that many others had not taken. For instance, one Sergeant had taken a rigid handcuffing course in 2015 (for the use of solid bar cuffs, rather than chain-link cuffs). Another Sergeant had taken a critical incident management course in 2022. A third officer had been trained on the use of the intoxylizer DUI test machine. However, these courses were not observed throughout the training regimens for the 10 officers OMB reviewed. OMB noted there seemed to be few courses that specifically addressed the needs of custody policing.

As one example, the case of Individual #1 identified earlier in the report in the Summary of Incidents was the subject of an OMB investigation under the Police (Complaints by the Public) Act. During interviews with OMB, the officers involved noted they completed officer safety training in line with RCIPS requirements. However, all stated that the safety training does not include detainee cell relocation or teamwork scenarios in situations where a detainee must be moved. This was required in the case of Individual #1 and the difficulties encountered in handling this prisoner were at least partly due to the officers lack of training in the process.

The RCIPS Guidance on Detention procedures manual provides in section 4.3 details of how to handle potentially violent prisoners, including identifying warning signs for physical violence and increased risk. The subsequent guidance sections note risks in restraining detainees in prone positions for any length of time and additional risks of positional asphyxia, which can lead to death in some instances.

Point 4.3.1 of the Guidance states "the safest way of dealing with a violent person is by rapid initial restraint by those who have had proper training." Point 4.5 of the Guidance, 'control within custody' states "staff working in a custody environment must be trained in the short-term management of violence." There are other similar areas of the Guidance which speak to the need for training in response to violence and tactical communications, but some considerable evidence that officers working there have not had custody-specific training to meet the goals set out in the Guidance. [9]

Both the CIDC Inspector and the RCIPS Superintendent raised issues about the need for training of CIDC officers. The Inspector noted one of his concerns is that some ACs working at the CIDC for longer periods of time haven't had refresher training. A curriculum was submitted for this training but had not been delivered at the time of the writing of this report.

In addition, the RCIPS managers noted, the majority of the time, PCs who are called in off the street to assist at CIDC have had no prior experience or training with working in custody and will not know how to enter data into the JMS computer records system. The Inspector further confirmed that there are RCIPS Sergeants who have been called into work at CIDC who have never worked in a custody role previously.

In OMB's view, this is a crucial gap for the RCIPS. The custody Sergeant is the officer with responsibility for the operational decisions of the CIDC at all hours. They make decisions on detentions, , they question new detainees on their health and wellness. They notify them of their rights and handle applications for police bail continuation, along with many other responsibilities. Much is expected of the officers placed in these positions. It is essential that they are trained properly to mitigate risks for the RCIPS.

In past years, the CIDC Inspector noted that training and working in custody was part of the training required to achieve promotion in the RCIPS from Sergeant to Inspector rank, but that is no longer done, he stated. Too often, the Inspector opined, assignment to the CIDC is viewed as a "punishment post".

There are further concerns about how long someone can safely work in a custody environment. At the time of OMB's investigation, there were a number of ACs who have been assigned to the position between 8-20 years and some have expressed concerns about working conditions and the toll it takes on mental health/nerves.

[9] RCIPS Guidance on Detention and Handling of Persons in Police Custody

Findings:

1. ACs are not all current on training and there remains some specialized training methods to which they don't have access.
2. Some ACs have been at the CIDC on terms longer than recommended by their supervisors, resulting in complaints of added stress/adverse health effects.

RCIPS response to OMB recommendations:

Recommendation 16 – Enhance Training Access & Compliance

- *Conduct a training audit to identify gaps in current AC training records.*
- *Ensure all ACs are up to date on mandatory training and have access to specialised modules relevant to custody operations.*

Status: Completed

- Full training audit completed.
- Curriculum for ACs & Sergeants near completion (due 31 Dec 2025).
- Rollout scheduled for January 2026.
- 2 staff attained master trainer 29th Nov. 2025(UCCI) as SME
- New Officer Personal Safety Training is being delivered to all staff commencing 2026. This is reflecting the new college of policing curriculum concentrating on application in real world policing scenarios. This includes specific scenarios in respect of the custody environment for example cell relocation, safe searching and safe removal and application of handcuffs.

Recommendation 18 – Implement Custody Policing Training Programme

- *Finalise and publish a training schedule for the proposed custody policing programme.*
- *Make participation mandatory for all CIDC personnel and offer access to other RCIPS officers as appropriate.*
- *Evaluate training outcomes through post-course assessments and feedback.*

Status: In Progress

- The RCIPS Training & Development Unit (TDU) is currently drafting the Custody Training Policy and training program. This will commence roll out in quarter one of 2026.

Note above in respect of new Officer Personal Safety Training curriculum, which will benefit all officers across the service, however has a particular focus on the safe custody of detainees.

- Publication targeted for 31 December 2025.
- Training to become mandatory for all CIDC personnel.
- There will be a full evaluation of the training and outcomes. In addition feedback from a range of sources (operational debriefs, Ombudsman / PSU recommendations, near miss reporting) in terms of organizational learning will be fed back into the training to ensure continuous improvement is embedded.

- **Language barriers**

The RCIPS Custody of Prisoners Policy (2018) states that the custody officer has ultimate responsibility as to whether an arrested/detained individual should be held:

Section 2.5.1 – "If the custody officer believes that there are insufficient grounds for detention or arrest, a custody record in JMS (Jail Information Management System) must be opened and the reasons for refusing detention must be recorded on the custody record and the prisoners must be released without unnecessary delay." [10]

Typically, the CIDC Sergeant will take personal details from the individual being detained, do a preliminary health and prisoner risk assessment, explain the individual's rights to them and supervise the process of their property being collected and stored. This is an important step in the prisoner detention process for several reasons, including the establishment of whether the CIDC Sergeant believes there is enough reason to warrant the individual's detention in the first place. OMB observed a few instances while embedded at CIDC where a language barrier contributed to a lack of clear communication between the detained person and the CIDC Sergeant. We recorded the following incidents:

Late at night on 14 June 2025 – A detainee was brought in for violating bail conditions. The individual spoke very little English and officers stated he appeared to be intoxicated when he was taken into custody. The CIDC Sergeant attempted to explain to the man that he would need to be kept overnight in lockup and that he was due back in court during the next week. The arresting

[10] RCIPS Custody of Prisoners Policy (2018)

officer reviewed the events which had led up to the detained man's arrest and the reasons for his suspicion around the detainee's conduct.

During the detainee's assessment, the CIDC Sergeant stated there was no way he could assess the prisoner because he wasn't understanding the questions being read to him. Whether this was because of intoxication, or because he didn't understand English very well, was unclear. For instance, during questions about his own health and fitness, the detainee kept speaking about his mother's ongoing illness. At one point, the detainee was so unresponsive, that an ambulance was called and he was transported to the hospital later that evening.

The evening of 12 June 2025 – Customs and Border Control (CBC) officers had brought in a group of Cuban nationals for booking into the CIDC, which is used byCBC for its detainees. Two of the men were let into the secure office area and were scanned with a metal detector wand. Both men spoke little English, but seemed to comply with the direction officers gave them. Both were put into detention cells. The CBC officers then explained to the RCIPS officers who the men were and why they were arrested.

Later the same evening, following the shift change at 7pm, the two on-duty ACs entered the cell area, attempting to get the correct spellings of the names of the Cuban detainees to enter them in the JMS system. This was difficult, as neither of the officers spoke Spanish and the Cuban detainees spoke little or no English.

Early morning of 7 June 2025 – A detainee, who was clearly intoxicated, was read his rights by the CIDC Sergeant, but didn't seem to understand or was paying little attention. The man stated he didn't want to contact an attorney or his country's consul, but he seemed confused about the paper the Sergeant was asking him to sign. The detainee, who spoke English, but didn't seem to understand the legal concepts being discussed with him, was stumbling around the booking area with a clipboard and pen in his hand. There were no officers in the booking area at this time, except for the Sergeant behind the booking desk and the OMB investigator who was observing. The detainee was booked into custody and submitted to a breath test for alcohol.

OMB reviewed these incidents with the CIDC Inspector and noted the following:

- There are individual RCIPS officers who can speak Spanish or Tagalog however, there are no designated translators for any non-English speaking detainees that CIDC has reliable access to.
- Particularly late at night or after hours on weekends, there is often no translator available
- Some officers will use their personal mobile devices to access Google translate or AI language applications, but this is done on an ad hoc basis.

- Translators are used for conducting investigative interviews with detainees, but those are typically scheduled with interviews taking place during business hours.

The CIDC Inspector notes that Cayman is an English-speaking country and all foreign workers who are permitted here must pass an English test. However, he acknowledged that having rudimentary English skills and being able to understand sometimes complex legal rights and concepts in a foreign language are very different things.

CBC/HMPS prisoners at CIDC

Somewhat ancillary to the language and communication issues is the influx of Customs and Border Control (CBC) prisoners being kept at CIDC. There are circumstances where, as observed during OMB's investigation, non-English speaking individuals must be kept at CIDC. In addition, there have been a number of individuals arrested in early 2025 for bringing in drugs which may be legal in other countries, but are not legal in Cayman. At the time of the writing of this report, CBC had no Memorandum of Understanding (MoU) with the RCIPS, as His Majesty's Prisons Service (HMPS) does for its prisoners. From time to time, HMPS remand prisoners are kept temporarily at the CIDC when HMP Northward (the men's prison) is at capacity. In those cases, HMPS will send its own staff members to the CIDC to look after its prisoners.

This is not so of CBC officers who typically book their prisoners through the CIDC Sergeant and then leave after they are safely in police custody. It is up to the RCIPS CIDC staff to house, feed and care for the CBC prisoners. This is an additional tax on RCIPS resources. However, in the CBC's view, their officers have nowhere else to book prisoners, particularly those who are brought in after hours.

It was understood from all three agencies- RCIPS, CBC and HMPS - that discussions are ongoing relative to the handling, housing and transport of prisoners. As of late 2025, CBC and RCIPS were working on creating a joint prisoner facility at the current CIDC site. HMPS and RCIPS were also in discussions, largely over prisoner transport responsibilities. As these discussions appear to be proceeding in good faith, OMB has made no further recommendations in relation to these matters.

Findings:

1. There are no regularly available translators for CIDC staff to assist with non-English speakers, particularly after hours
2. Translators are typically arranged ahead of time for investigative interviews
3. The lack of effective translation creates potential risks for the CIDC officers who may wrongfully detain persons or worse, misunderstand and thus neglect medical conditions.

Recommendations:

As this section was not included in the Interim Report, the Ombudsman has made additional recommendations:

1. The RCIPS should consider the feasibility of having an on-call rota of translators for key languages, including Spanish, Tagalog and Hindi. Participants could be incentivised to perform this community service as volunteer work.
2. The RCIPS should report back to the OMB within three months of the presentation of this report to the Commissioner of Police on any progress in obtaining translators.

Additional matters for consideration:

OMB has referenced the 2021 RCIPS Custody Review report in our investigation, which was a helpful guidance document and we have, as part of this OMI, spoken to its author. We are not aware that the entire report has ever been made public, however we note below several key recommendations in the Custody Review that were provided to the former Commissioner of Police, many of which mirror some of the Ombudsman's own recommendations.

To the extent these have not been actioned by the RCIPS, OMB believes they are relevant and worthy of consideration. The recommendations below were presented to the RCIPS senior management team in 2022.

1.Cell ligature/self-harm points *- Enclose privacy screens in each cell to alleviate ligature points. Consider capping toilet paper tube for the same reason. Consideration to be given to enclose the beds in Corian or similar hardened plastic structures to prevent injury or self-harm. Similarly, the underside of the bed space should be enclosed to prevent detainees using that area for disguising illicit or dangerous activity.*

2. Risk Assessment and risk management *- Immediately implement HQ Directive (redacted). A risk assessment should be conducted of every person brought into Custody, without fail. Doing so minimises the risk of adverse incidents during or post detention. Custody Sergeants must direct detention staff on the observation level of every detainee and ensure that those safety checks are conducted timely and professionally, as well as being accurately recorded on the Custody record.*

Risk assessments should be revisited throughout the period of detention of a detainee, especially at significant times such as when reminded of their rights or on charge and bail refusal.

3. Detainee safety visits - *Immediately implement HQ Directive (redacted), a four-level observation check system within Custody for every detainee. Immediately implement accurate recording or all cell visits and interactions with detainee, throughout their period of detention. Ensure that the Observation Level is noted on the Custody record by the Custody Sergeant following completion of the risk assessment. Custody Sergeants to monitor and check completion of checks by Custody staff. Implement a cell check proforma to ensure checks are conducted in line with directive. This proforma is to be retained for a minimum period as set out by supervision. Retaining it in line with current disclosable documentation may be avoided if it can be shown that checks are made to compare information held on the 'temporary' proforma and has been uploaded accurately onto the respective Custody records. A checks and balances assessment may be required by supervision to ensure this is complied with.*

4. Software options *–(Redacted) An FCDO funded project is being commenced (redacted) to review the existing IT applications used by the OT's, OTRCIS being the base platform. This may offer opportunities for pan-OT system delivery over the next 12 months. This system has the functions to not only continue to manage Intelligence and CRO, but also become the Service's record and custody management systems.*

5. Bail Management/Bail Sergeant *- The responsibility for bail remains that of the Custody Sergeant. While it is accepted there may be occasions whereby a gaoler could assist to expediate the process, this should not remain common practice. With restructuring of tasks, gaolers will need to place more emphasis detainee welfare and security An electronic bail diary to be provided within JMS to negate the manual diary currently in use, preventing unnecessary storage and data risk. In the meantime, use of the JMS built in the 'Facility Events' button should be utilised. Reduce re-bails by providing a realistic first period of bail. Where it appears obvious to the Custody Sergeant that an investigation is likely to be protracted, an extended first period of bail should be given to negate back and forth bail returns. Officers must ensure that the detention log is updated for every individual who returns on bail, with information on time spent in Custody, the outcome and any representations. Embed the 'extra' Custody Sergeant as the Bail Sergeant, with ownership of reducing bail, adivising officers on relevant bail periods and dealing with all bail returns during the tour of duty (9-5 Monday to Friday, but available for shift cover in the absence of Custody Sergeants)*

6. Voluntary Interview rooms (non-arrest) - *Introduce an interview room in each of the police stations at George Town, Bodden Town and West Bay. This would alleviate the need for officers to travel to the Detention Centre merely to interview suspects. The proviso however, would be that ONLY suspects not under arrest or on bail for the offence for which they are being interviewed,*

should be interviewed at the police stations. In order to ensure best, incorruptible evidence, audio recorded interviews should be utilized as a minimum. (Audio/Video ideally)

7. Prisoner Transport Records *- Immediately (re)introduce the requirement for EVERY transferred detainee to have a completed Prisoner Transport Record be completed and ensure that form is signed on handover by the receiving agent and details of any incident recorded on the form. That form should then be uploaded to JMS. The forms need to be carbonised in order to provide an original and the minimum of a second copy for handover to the recipient. These forms will need to be stored in accordance with local requirements. Details of all medical and risk concerns MUST be recorded on this form.*

8. External Building corrosion and erosion - *On the exterior of the building, signs of rust and decay are beginning to show. Work may be required to repair, inhibit further decay and repaint the building to prolong its use. The warranty for the building should be revisited and Eagle Detention Facilities/CIG Estates requested to examine the building at the earliest opportunity Razor wire across the top of the fencing requires repair in places.*

9. Cell call Buttons and Attack alarms *- Every cell should be provided with a call button system which indicates to staff which cell number is calling. The provision of a two-way intercom with each individual cell further improves the detainee standard of care and attention while in the cell. Attack alarm strips should be mounted along both cell corridors, in all rooms where detainees may be interviewed, in consultation, process and the Intoxyliser room. Those alarms should notify the Custody Sergeant and other staff by means of a control panel, indicating the position of the alarm activation. Cell keys should be carried by all detention officers as a matter of policy. This may require further sets to be purchased.*

10. Government CCTV - *The Government CCTV needs to be reviewed, with requests for increased camera number and larger, working monitors for the area within the Detention Centre. This action should be prioritised with a minimum requirement that the current system is fixed to allow monitoring in its current state and location.*

Conclusion:

The findings presented in this OMI reflect systemic issues which, if unaddressed, pose significant risks to the safety of detainees, RCIPS staff, the broader public, as well as the integrity of the RCIPS.

The OMB acknowledges that some remedial efforts have been completed and others are under way. These have been updated as a result of the Interim Report.

However, the persistence of long-standing issues—such as inadequate staffing, unclear medical transport protocols, poor internal security practices, and delayed maintenance—demonstrates the need for a more structured and accountable approach to facility management and oversight.

The recommendations provided in this report are intended to support the RCIPS in addressing these deficiencies through clear policy amendments, improved inter-agency coordination, enhanced training, and infrastructure upgrades. The Ombudsman strongly encourages the Commissioner of Police and Her Excellency the Governor to treat these matters with the urgency they deserve and to initiate immediate steps toward implementation.

Sharon Roulstone
Ombudsman

Dated: 20 March 2026

Appendix A – OMB Recommendations actioned by RCIPS

Status key: Completed | In Progress | Pending / Delayed

Number	Recommendation Summary	Status	Notes
1	**Medical Escort Responsibilities**	Completed	Policy section 4.4 identifies IO/Service Delivery: Directive has been issued by the Commissioner of Police clearly outlining ownership & responsibilities dated 9th December 2025
2	**MoU & Communications with HSA**	In Progress	Meetings held; CIDC to be visited by HSA rep to assess and develop a pilot program to place a health care professional within CIDC. Date of visit has not yet been confirmed.
3	**Fire Alarm Certification**	In Progress	Final test and evacuation drill successfully took place on 5th Dec. Building Control Unit booking final inspection within the next 4 weeks. However, generator board replacement required which has been actioned (does not adversely affect the fire alarm).
4	**Independent Fire system Review**	Completed	Full internal review finalized 26 Nov 2025.
5	**Internal Door Security & Lock Protocols**	In Progress	Alarm installation nearly complete; locks serviced. (by 30th Dec. 2025)
6	**Escape Risk Procedures**	Completed	2022 escape attempt review complete and embedded in SOPs.
7	**Emergency Access Keys & Override**	Completed	Keys delivered & verified on 4 Dec 2025.

8	**Maintenance Response Protocol**	Completed	Daily check sheets + reporting active.
9	**Incident Damage Investigation**	Completed	S.A.F.E.R form produced for reporting.
10	**Eliminate CCTV Blind Spots**	In Progress	Final camera installation expected 19th Dec 2025.
11	**Staffing Needs & Contingency**	Pending	Budget approved; recruitment begins 2026.
12	**Female AC Representation**	Pending	Recruitment challenges persist. However targeted campaign planned for January 2026.
13	**Reduce Overwork & Stress**	In Progress	Service wide health and wellbeing strategy has been implemented. Additional staffing planned will relieve pressure in 2026. HQ directive in respect of monitoring breaks issued.
14	**Wellness Support for CIDC Staff**	In Progress	Wellness program has been initiated service wide for all staff. Specific HQ directive to ensure breaks are taken when cover is available has been circulated.
15	**Custody sergeants/AC Rotation Limit (2 Years)**	Pending	A service wide posting panel is due to take place January 2026 to review all sgt postings and rotation in line with new promotions. Pending AC recruitment rotation of AC's will also be progressed.
16	**Training Compliance**	Completed	Training audit complete; curriculum development in progress due completion by 31 Dec 2025 for roll out in quarter one 2026.
17	**Transition Plan for Long-Serving ACs**	Pending	Linked to rec. 15 & recruitment plan for 2026
18	**Custody training Policy Programme**	In Progress	Policy & schedule under development by TDU for roll out in quarter one 2026.

Appendix B – New OMB recommendations based on additional findings

Recommendations in relation to detainee self-harm attempts –

1.RCIPS should review self-harm/injury incidents occurring within the past three years at CIDC to identify additional areas of training officers may require, including in initial detainee assessment and psychological evaluations
2.A report of the review referenced in point #1 should be presented to the Ombudsman within six months of the submission of this investigation's findings to the Commissioner of Police.

Recommendations in relation to detainee welfare checks –

1. RCIPS should consider whether another method – such as a prisoner log sheet, posted outside each cell door – could be used by officers and then updated once at the end of one shift, or the beginning of the next.
2. RCIPS should monitor the inmate logs in JMS for quality assurance.
3. OMB will review prisoner logs again in six months, following the submission of this investigation report to the Commissioner of Police.

Recommendations in relation to CIDC general intake procedures –

1. The RCIPS Custody of Prisoners policy regarding searches should be strictly enforced and a reminder on its requirement sent to all personnel at CIDC
2. A policy should be created for the use of metal detector wands, ideally to wand all detainees who come in at least once
3. Clarify current policy regarding handcuffing and supervision of detainees while they are on the booking area floor. Please send policy updates to the Ombudsman.
4. The Ombudsman will consider whether a review of document security at CIDC by OMB's Information Rights Team is warranted

Recommendation in relation to detainee interviews/attorney consultations –

1.The OMB recommends the RCIPS consider using the two larger rooms not currently in use for interviews and would request the RCIPS report back within 30 days of this report being submitted to the Commissioner of Police regarding why these rooms cannot be used, if that is the case.

Recommendations in relation to the language barrier –

1. The RCIPS should consider the feasibility of having an on-call rota of translators for key languages, including Spanish, Tagalog and Hindi. Participants could be incentivised to perform this community service as volunteer work.
2. The RCIPS should report back to the OMB within three months of the presentation of this report to the Commissioner of Police on any progress in obtaining translators.