

## NEGLIGENCE OF MEMBERS OF THE NATIONAL POLICE OF THE REPUBLIC OF INDONESIA IN SUPERVISION OF TEMPORARY PRISONERS OF THE DRUG INVESTIGATION UNIT (CASE STUDY OF EXAMINATION MINUTES NUMBER BP/03/V/2025/SIPROPAM)

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### Abstract

This study analyzes alleged negligence by Indonesian National Police officers in supervising temporary detainees of the Narcotics Investigation Unit, based on Examination Report Number BP/03/V/2025/SIPROPAM at Batu Bara Police. The research examines forms of negligence, the application of legal rules and supervision procedures, and the forms of legal accountability that may arise. Using empirical legal research supported by statutory and doctrinal materials, the study assesses duty rosters, guard obligations, mutation books, handover practices, cell security, reporting, and supervisory control. The findings show that negligence must be established individually through a clear duty, a departure from the required standard of care, foreseeability and preventability of risk, and a causal connection with the relevant consequence. Accountability may take disciplinary, professional-ethical, administrative, and in certain circumstances criminal forms, but criminal responsibility requires a specific offense, culpa, legally relevant consequence, and causation.

**Keywords:** police negligence; detainee supervision; discipline; professional ethics; legal accountability

### 1. Introduction

Detainees held by the police remain under state control and therefore require continuous protection of their security, safety, presence, and basic rights. A temporary cell within a narcotics investigation unit does not eliminate the institutional duty of care merely because it is not a permanent detention facility. Supervision must therefore be organized through clear duties, physical checks, documentation, handovers, reporting, and command responsibility (Kelana, 2014; Sadjijono, 2010).

The source study focuses on Examination Report Number BP/03/V/2025/SIPROPAM at Batu Bara Police. The legal problem concerns whether police officers failed to perform supervision duties to the standard required by their positions and whether such failure can be attributed individually. This requires more than identifying the officers listed on a duty roster because the actual conduct of each officer must be reconstructed.

Negligence in detainee supervision can occur through failure to conduct periodic checks, failure to inspect doors, locks, bars, ventilation, or other security points, incomplete mutation-book entries, inadequate handover, absence from the post without replacement, delayed response to risk, or failure to report damaged security facilities. Each form reflects a different relationship between duty and risk. The legal assessment must therefore identify exactly what the officer was required to do and what was actually done.

Administrative records have an important evidentiary function in this setting. Duty orders, guard schedules, mutation books, handover notes, incident reports, and supervisory records can establish who had responsibility at a particular time and what information was available. However, the source thesis emphasizes that complete paperwork cannot substitute for physical supervision, just as physical checks without records can create later problems of accountability.

The case also raises a distinction between individual fault and system weakness. Insufficient personnel, defective facilities, unclear division of tasks, or weak command supervision may increase the risk of failure, but these conditions do not automatically erase an

officer's personal duty. Conversely, institutional shortcomings should not be ignored by placing all responsibility on the lowest-ranking officer without examining the broader control system.

Police accountability can operate through several legal forums. Breach of service obligations may lead to disciplinary responsibility, conduct inconsistent with professional dignity may lead to ethics proceedings, and administrative consequences may follow from employment status or organizational decisions. Criminal liability is different because it requires a specific offense, culpable negligence, a relevant consequence, and a causal relationship that satisfies criminal-law standards (Huda, 2006; Hiariej, 2016).

The source interviews, including the explanation of AIPTU U.P. Tambunan, emphasize that internal examination should provide the member an opportunity to explain the context and submit evidence. The examiner should focus on verifiable facts such as time, place, orders, actions, witnesses, documents, and response. This procedural fairness helps distinguish a proven breach from an assumption based solely on the occurrence of an incident.

This study consequently examines three issues: the forms of police negligence in temporary-detainee supervision, the application of legal rules and supervision procedures, and the legal accountability of officers found negligent. The analysis is grounded in the source thesis and the official examination file. Its central principle is that responsibility must be personalized according to role, period of duty, authority, knowledge of risk, opportunity to prevent harm, and individual evidence.

## **2. Methodology**

### **2.1. Research Methodology**

The research uses empirical legal research supported by normative analysis. Primary data are drawn from the internal examination material and interviews concerning supervision practices, while secondary materials include the Police Law, the Criminal Procedure Code, disciplinary rules, the Police professional code of ethics, and criminal-law literature. Qualitative analysis is used to compare formal duties with actual supervision and accountability practices.

The object of analysis is the temporary detention room of the Narcotics Investigation Unit at Batu Bara Police. The study reviews the relationship among duty assignments, physical supervision, administrative records, facility conditions, reporting, and command oversight. These components are examined together because a supervision failure can arise from action, omission, communication failure, or institutional control weakness.

The research does not treat an adverse incident as automatic proof of negligence. It tests whether the officer had a clear duty, whether the risk was foreseeable, whether prevention was reasonably possible, whether the officer deviated from the required standard, and whether the deviation contributed to the relevant consequence. This structure preserves the principle of individual responsibility while allowing system factors to be evaluated.

### **2.2. Theoretical Foundations**

Negligence or culpa is a form of fault based on a failure to exercise the care required in circumstances where a harmful consequence could and should have been anticipated. In professional settings, the applicable standard is shaped by the officer's position, instructions, procedures, training, and actual ability to respond. The source thesis therefore treats negligence as a relationship between legal duty and preventable risk rather than as mere imperfection (Ali, 2019; Prasetyo, 2016).

Police discipline and professional ethics have distinct but related functions. Discipline maintains compliance with service obligations and organizational order, while the professional code addresses integrity, responsibility, and conduct affecting the dignity of the institution. A single event may engage more than one forum, but each forum must apply its own elements and procedural safeguards (Jurdi, 2022).

Criminal liability requires a higher threshold than a procedural or administrative breach. Not every incomplete entry, delayed report, or imperfect handover is a criminal offense, even though it may justify internal accountability. Criminal responsibility can arise only where the law defines the prohibited conduct and the required fault, consequence, and causal connection are proven.

### **2.3. Legal Arrangements and Key Concepts**

The legal framework identified in the source thesis includes the Criminal Procedure Code, Law Number 2 of 2002 concerning the Indonesian National Police, Government Regulation Number 2 of 2003 on Police discipline, and Police Regulation Number 7 of 2022 concerning the professional code of ethics and ethics commission. These rules establish institutional authority, duties toward detainees, professional obligations, and accountability mechanisms. They must be read together with internal procedures for detainee care and supervision.

Supervision procedure should cover admission and recording of detainees, identity and health checks, searches and control of prohibited items, appropriate placement, periodic counting and condition checks, inspection of security facilities, guard scheduling, mutation-book entries, handover, incident reporting, and hierarchical supervision. Each stage has a preventive function and also creates an audit trail. Failure at one stage can increase risk at later stages.

The concept of handover is particularly important because responsibility shifts over time between officers. An adequate handover should communicate detainee numbers, special risks, facility defects, recent incidents, and any action requiring follow-up. Without a reliable handover, a new guard may inherit risks without adequate knowledge, while the previous guard may leave unresolved conditions undocumented.

### **2.4. Parameters of Juridical Analysis**

The first parameter is the existence of a clear individual duty based on an order, roster, position, or direct instruction. The second is deviation from the standard of care, the third is foreseeability and preventability of risk, and the fourth is the relationship between the omission and the resulting problem. These parameters prevent collective blame from replacing evidence about each member's conduct.

A second parameter concerns institutional conditions. The analysis considers whether personnel were sufficient, whether doors and locks were functional, whether the guard could observe the detention room, whether the reporting channel worked, and whether supervisors responded to previous warnings. Such conditions may affect the degree of fault and the reasonableness of expected preventive action.

A third parameter concerns proportional accountability. The appropriate response depends on the nature of the obligation violated, the level of fault, the consequence, motive, prior knowledge, preventive efforts, conduct after the incident, and the member's role. The same incident can therefore justify different outcomes for different officers if their duties and contributions were not identical.

## **3. Research Results**

### **3.1. Forms of Police Negligence in Temporary-Detainee Supervision**

The research identifies several potential forms of negligence: failure to conduct direct periodic checks, failure to count detainees, failure to inspect doors, locks, bars, or ventilation, incomplete mutation-book entries, incomplete handover, leaving the post without replacement, delayed response, and failure to report security defects. These are not treated as interchangeable because each reflects a different duty and preventive function. Proof must show which obligation applied to the particular officer.

Duty rosters are a starting point but are not conclusive proof of personal fault. The examination must determine when the officer actually assumed control, what information was received, what inspections were performed, and what risks were visible or reported. The source thesis therefore rejects collective responsibility based only on membership in the same shift or unit.

The assessment also considers whether the risk could reasonably have been anticipated and prevented. An officer who knew of a damaged lock, unusual detainee behavior, or another concrete risk and did not report or address it may have a different level of fault from an officer who had no reasonable opportunity to discover the condition. This differentiation is central to fair accountability.

The source thesis places responsibility for temporary detention supervision on the officer who actually holds the relevant duty at the time, not on police personnel collectively. The assessment therefore begins by identifying the guard schedule, handover record, orders from superiors, and the concrete acts of inspection that were or were not performed, because a finding of negligence requires a specific duty that could realistically be carried out. AIPTU U.P. Tambunan explained that a general statement that the cell was 'safe' is insufficient when it is not supported by the time, method, result, and documentation of the inspection.

Supervision is treated as a risk-management obligation because temporary narcotics detention rooms carry foreseeable risks of escape, violence, health emergencies, prohibited objects, and interference with investigation. The standard becomes more demanding when officers have received prior warnings, observed damaged facilities, noticed suspicious behavior, or obtained information indicating a particular risk, since these facts increase the foreseeability of harm. This framework connects negligence with what the officer knew or should have known and with the precaution that a professional officer was expected to take in response.

### **3.2. Application of Rules and Supervision Procedures**

The proper procedure combines physical supervision with administrative traceability. Officers should inspect detainees and security facilities, record the results, conduct handover, report abnormalities, and obtain supervisory direction when necessary. The source thesis finds that procedure protects both detainees and officers only when it is actually implemented and documented.

A mutation book should record the time, action performed, result of inspection, identity of the responsible officer, and any follow-up. A generic entry that merely states that conditions are "safe" provides limited information if later review cannot determine what was checked. Detailed recording therefore functions as a control instrument and as evidence of whether supervision was genuinely conducted.

Hierarchical supervision is also part of the procedure. Supervisors should review staffing, facility condition, recurring risks, and the consistency between written records and actual conditions in the cell. Where leaders have ignored repeated reports or failed to establish workable guard arrangements, the evaluation should not stop at the conduct of the officer physically present at the post.

The legal and procedural framework for detention supervision operates through several layers rather than through a single rule. Criminal procedure establishes the lawful basis for detention, police regulations determine institutional responsibility and technical custody arrangements, while disciplinary and ethical rules define professional conduct and consequences for failures in duty. The source thesis therefore rejects reliance on informal local

habits where those habits conflict with formal obligations, because routine practice cannot displace a binding standard intended to protect detainee security and rights.

Temporary placement within a functional unit such as the narcotics investigation unit does not reduce the need for coordination with the unit responsible for detainee care or other designated officials. According to AIPTU U.P. Tambunan, limited facilities actually make clear task allocation more important, especially where an officer has multiple assignments or must leave the observation area for another duty. A replacement, handover, and written record are necessary to prevent a gap in responsibility in which every officer assumes that another person is monitoring the detainees.

### **3.3. Legal Accountability of Negligent Officers**

The source thesis finds that disciplinary accountability may arise when an officer fails to fulfill service obligations or violates internal order. Professional-ethical accountability may arise where the conduct undermines responsibility, professionalism, or institutional dignity, while administrative consequences may follow according to personnel rules. These forums can address conduct that does not satisfy the elements of a criminal offense.

Criminal accountability is possible only in particular circumstances. Internal evidence may provide initial information, but a criminal process must independently prove a statutory offense, negligence, a legally relevant consequence, and causation under criminal-procedure rules. This distinction prevents internal proceedings from substituting for criminal investigation or criminal law from being used for every procedural violation.

The responsibility of each member must be individualized according to duty, period of control, knowledge of risk, opportunity to prevent the event, actions taken, and supporting evidence. The source interview explains that a previous guard, a new guard, and a shift leader may all have different obligations and therefore should not automatically receive the same sanction. Proportionality requires a reasoned written explanation for the chosen outcome.

Contemporaneous records are particularly important because an internal examination may reveal differences between later oral explanations and entries made during the duty period. A reliable log should show a consistent time sequence, identify the officer who made the entry, and correspond with witness accounts, CCTV where available, and the physical condition of the cell, while entries completed after the event must be distinguished from records made at the time. Digital systems can strengthen accountability only when they preserve user identity, timestamps, and an audit trail that prevents silent alteration of the record.

The source thesis also recognizes that objective professional standards must be applied to the real operational setting. The number of officers and detainees, available facilities, competing assignments, specific risk information, and emergency conditions may affect what preventive action was actually possible, although institutional limitations do not automatically erase basic duties. A balanced analysis therefore distinguishes between a preventable omission attributable to the officer and a systemic constraint that should instead be addressed through staffing, equipment, or organizational reform.

## **4. Discussion**

### **4.1. Analysis of the Forms of Negligence**

The identified forms of negligence show that detainee supervision is a continuous process rather than a single act of locking a cell. Periodic visual checks, facility inspection, counting, record keeping, and handover each address a different risk. Omitting one function may leave another officer or supervisor without the information needed to prevent a later incident.

Personalization of responsibility is legally preferable to collective blame. A roster proves assignment but not necessarily what an officer knew, did, or could have done, so it must be supplemented by mutation entries, witness statements, facility evidence, and communication records. This approach is consistent with the principle that sanctions should respond to individual fault.

System conditions should be treated as relevant context without becoming an automatic excuse. A defective cell, insufficient staffing, or unclear orders can reduce the practical capacity of an individual officer and may expose a supervisory failure, but the officer may still be required to report the problem or take available protective action. The analysis therefore needs both individual and organizational levels.

Accountability for negligent supervision can arise in disciplinary, ethical, administrative, civil, or criminal forms, and each has a different legal function. Discipline concerns obedience to service obligations, the professional code concerns conduct and institutional honor, administrative measures concern employment and command responsibility, while criminal punishment requires a statutory offense, fault, and the other elements of criminal responsibility. Keeping these regimes conceptually separate prevents an administrative deficiency from being criminalized without basis while also preventing a serious and blameworthy failure from being minimized as a mere paperwork problem.

The BAP examined in the source study is therefore only one component of the proof needed to determine responsibility. Statements by the officer must be compared with contemporaneous duty documents, witnesses, the physical condition of security facilities, and any electronic records, because an admission or denial should not become the sole foundation of the conclusion. Where records are incomplete, reconstruction may still be possible, but the examiner should expressly state the limitation so that the final decision remains transparent about the strength and weakness of its evidentiary basis.

#### **4.2. Analysis of Legal Rules and Procedures**

The source thesis correctly emphasizes that documentation and physical supervision must support each other. A well-completed mutation book cannot compensate for the absence of direct checks, and diligent checks that leave no record make later verification difficult. Effective supervision requires both action and a reliable administrative trail.

The handover mechanism deserves special attention because many supervision failures occur at transitions between shifts. The outgoing officer should disclose unresolved risks and the incoming officer should verify detainee numbers, cell condition, and key information rather than rely entirely on the previous report. This two-sided duty reduces gaps in responsibility and creates clearer evidence when a problem occurs.

Hierarchical audit should test not only whether documents exist but whether they correspond with real practice. Random physical inspections, comparison of records with facility conditions, and review of recurring problems can reveal formal compliance that masks operational weakness. Such supervision also helps identify whether a failure is individual, systemic, or both.

Proportionality is also required when selecting a sanction because not every failure in supervision has the same gravity. A limited administrative omission that is quickly corrected may justify a lighter response, while prolonged neglect, repeated violation, deliberate concealment, or a serious consequence can support a substantially heavier disciplinary or ethical measure. The source thesis notes that the decision should explain why the chosen sanction corresponds with the degree of fault so that comparable cases are not treated arbitrarily and the sanction retains a meaningful corrective function.

Relevant factors include the level of fault, duration of the omission, magnitude of risk, resulting harm, the officer's position, prior violations, honesty during examination, cooperation,

and efforts to mitigate or report the problem. Systemic shortcomings such as staffing or inadequate facilities should be documented because they may affect the officer's actual capacity, but they should not be used to erase a basic obligation where the officer knew of the risk and simply failed to act. This individualized assessment helps distinguish personal negligence from organizational weakness and clarifies which corrective measures should be directed at the officer and which should be directed at the institution.

#### **4.3. Analysis of Legal Accountability**

The separation among discipline, ethics, administration, and criminal law is essential to proportionality. A service breach may be serious without constituting a crime, and an ethics violation may involve institutional dignity even where no material criminal consequence is proven. Applying the correct forum prevents both under-enforcement and excessive criminalization.

Procedural fairness in internal examination strengthens the legitimacy of accountability. Officers should be informed of the facts under review, allowed to explain the context, and permitted to submit supporting evidence, while examiners should rely on verifiable data and written reasons. This protects the presumption of innocence without weakening organizational discipline.

The source thesis also supports remedial action after an incident, including re-securing the detainee environment, medical attention where necessary, preservation of evidence, reporting, and system evaluation. Accountability is therefore not complete when a sanction is imposed. The institution must also correct the conditions that allowed the failure to occur.

The source interview recommends scenario-based training so that guards can practice responses to health emergencies, damaged security facilities, conflict among detainees, and attempted breaches of custody rules. Such training should be linked to competency assessment, accessible standard operating procedures, and clear escalation channels, because rules are more effective when personnel can translate them into decisions under real operational pressure. The objective is to transform detention supervision from passive observation into planned risk control supported by documentation and command oversight.

Complex negligence cases may also benefit from a case conference or evaluation forum so that the conclusion is tested by more than one examiner, although collective discussion does not eliminate the responsibility of the official who makes the decision. Consistency can be strengthened through internal guidance, a searchable body of prior decisions, and transparent reasons communicated to the examined officer, which together reduce unexplained disparity. These institutional measures complement individual accountability by using the investigation of one incident to improve future custody practices and prevent recurrence.

The source study further shows that handover between officers is one of the most vulnerable points in detention supervision because responsibility can become unclear when information about detainee condition, security defects, medical needs, or special risks is not transferred accurately. A meaningful handover should therefore identify the number and identity of detainees, recent incidents, restrictions or treatment needs, the condition of doors and locks, prohibited items already seized, and any instruction requiring closer observation, with both the outgoing and incoming officer able to verify what was communicated. When this record is absent, an internal examiner must reconstruct not only whether a harmful event occurred but also whether the officer who is blamed had actually received the information necessary to foresee and prevent it.

Physical security and human supervision operate as complementary safeguards rather than substitutes. Strong locks, barriers, cameras, lighting, and alarm systems reduce opportunity and improve detection, but they do not eliminate the requirement for periodic direct checks,

while diligent personnel cannot always compensate for a structural defect that allows a detainee to defeat the security arrangement. The source thesis consequently supports a dual evaluation in which the examiner identifies personal omissions and institutional deficiencies separately, so that disciplinary responsibility can be directed at an officer where appropriate and organizational corrective action can address defective facilities, staffing patterns, or procedures that create recurring risk.

Documentation also has a preventive function because officers who know that checks, handovers, and unusual events must be recorded are more likely to perform those duties in a structured and reviewable way. A complete log permits supervisors to detect excessive gaps between inspections, repeated equipment problems, or unusual patterns before they develop into a serious incident, thereby turning paperwork into an early-warning mechanism rather than a record created only after failure. In this sense, the source thesis links accountability with prevention: records support the investigation of an incident that has already occurred, but their greater institutional value is to make emerging risks visible while intervention is still possible.

The distinction between individual fault and command responsibility should likewise be maintained in a complex custody failure. The guard who directly omits a required check may bear personal responsibility, while a supervisor can have a different form of responsibility if unsafe staffing, ignored reports, unclear instructions, or known facility defects are allowed to persist, and those forms should not be merged into a collective allegation that every member is equally negligent. An individualized analysis of duty, knowledge, authority, opportunity to act, and causal contribution therefore protects fairness to the personnel examined while also preventing higher-level management failures from disappearing behind the conduct of the officer who happened to be physically closest to the cell.

## 5. Conclusion

Police negligence in temporary-detainee supervision must be identified from a clear service duty, deviation from the required standard of care, foreseeability and preventability of risk, and a causal relationship with the relevant consequence. Potential forms include failure to conduct periodic checks, inspect security facilities, record supervision, perform a complete handover, remain at the post, respond to risk, or report defects. Responsibility should be individualized and not imposed collectively merely because several officers belonged to the same unit or shift.

The applicable supervision framework combines criminal-procedure duties, the Police Law, discipline rules, the professional code of ethics, and internal detainee-care procedures. Effective implementation requires physical control, accurate documentation, communication, handover, reporting, and hierarchical supervision. Compliance therefore has to be assessed as a practical system rather than as the presence of paperwork alone.

Legal accountability may take disciplinary, professional-ethical, administrative, and in certain circumstances criminal forms. Criminal responsibility requires a specific statutory offense, culpable negligence, a relevant consequence, and causation, while internal sanctions must remain proportional to the officer's role, knowledge, opportunity to prevent the event, and proven fault. The institutional response should also include system correction when staffing, facilities, task division, or supervisory control contributed to the problem.

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## References

- (1) Ali, Mahrus. *Dasar-Dasar Hukum Pidana*. Jakarta: Sinar Grafika, 2019.
- (2) Ali, Zainuddin. *Metode Penelitian Hukum*. Jakarta: Sinar Grafika, 2021.

- (3) Bachtiar. Metode Penelitian Hukum. Tangerang Selatan: Unpam Press, 2019.
- (4) Efendi, Jonaedi dan Johnny Ibrahim. Metode Penelitian Hukum Normatif dan Empiris. Depok: Prenadamedia Group, 2022.
- (5) Harahap, M. Yahya. Pembahasan Permasalahan dan Penerapan KUHAP Penyidikan dan Penuntutan. Jakarta: Sinar Grafika, 2016.
- (6) Hiariej, Eddy O.S. Prinsip-Prinsip Hukum Pidana. Yogyakarta: Cahaya Atma Pustaka, 2016.
- (7) Huda, Chairul. Dari Tiada Pidana Tanpa Kesalahan Menuju kepada Tiada Pertanggungjawaban Pidana Tanpa Kesalahan. Jakarta: Kencana, 2006.
- (8) Irwansyah. Penelitian Hukum: Pilihan Metode dan Praktik Penulisan Artikel. Yogyakarta: Mirra Buana Media, 2020.
- (9) Ishaq. Metode Penelitian Hukum dan Penulisan Skripsi, Tesis, serta Disertasi. Bandung: Alfabeta, 2020.
- (10) Jurdi, Fajlurrahman. Etika Profesi Hukum. Jakarta: Kencana, 2022.
- (11) Kelana, Momo. Hukum Kepolisian. Jakarta: PTIK Press, 2014.
- (12) Moeljatno. Asas-Asas Hukum Pidana. Jakarta: Rineka Cipta, 2008.
- (13) Muhaimin. Metode Penelitian Hukum. Mataram: Mataram University Press, 2020.
- (14) Prasetyo, Teguh. Hukum Pidana. Jakarta: RajaGrafindo Persada, 2016.
- (15) Reksodiputro, Mardjono. Hak Asasi Manusia dalam Sistem Peradilan Pidana. Jakarta: Pusat Pelayanan Keadilan dan Pengabdian Hukum Universitas Indonesia, 2007.
- (16) Sadjijono. Memahami Hukum Kepolisian. Yogyakarta: LaksBang Pressindo, 2010.
- (17) Santoso, Topo. Hukum Pidana: Suatu Pengantar. Jakarta: RajaGrafindo Persada, 2020.
- (18) Soekanto, Soerjono dan Sri Mamudji. Penelitian Hukum Normatif: Suatu Tinjauan Singkat. Jakarta: Rajawali Pers, 2015.
- (19) Supramono, Gatot. Hukum Narkoba Indonesia. Jakarta: Djambatan, 2017.
- (20) Undang-Undang Dasar Negara Republik Indonesia Tahun 1945.
- (21) Kitab Undang-Undang Hukum Pidana.
- (22) Undang-Undang Nomor 1 Tahun 2023 tentang Kitab Undang-Undang Hukum Pidana.
- (23) Undang-Undang Nomor 2 Tahun 2002 tentang Kepolisian Negara Republik Indonesia.
- (24) Undang-Undang Nomor 8 Tahun 1981 tentang Hukum Acara Pidana.
- (25) Undang-Undang Nomor 35 Tahun 2009 tentang Narkotika.
- (26) Peraturan Pemerintah Nomor 2 Tahun 2003 tentang Peraturan Disiplin Anggota Kepolisian Negara Republik Indonesia.
- (27) Peraturan Kepolisian Negara Republik Indonesia Nomor 7 Tahun 2022 tentang Kode Etik Profesi dan Komisi Kode Etik Polri.
- (28) Putra, Ayranda Eka, Amancik, dan Ismail Jalili. "Analisis Pengurusan dan Perawatan terhadap Tahanan Pelaku Tindak Pidana Narkotika di Rumah Tahanan Polda Bengkulu." Jurnal Multidisiplin Dehasen (MUDE) 4, no. 4 (2025): 1181–1186.