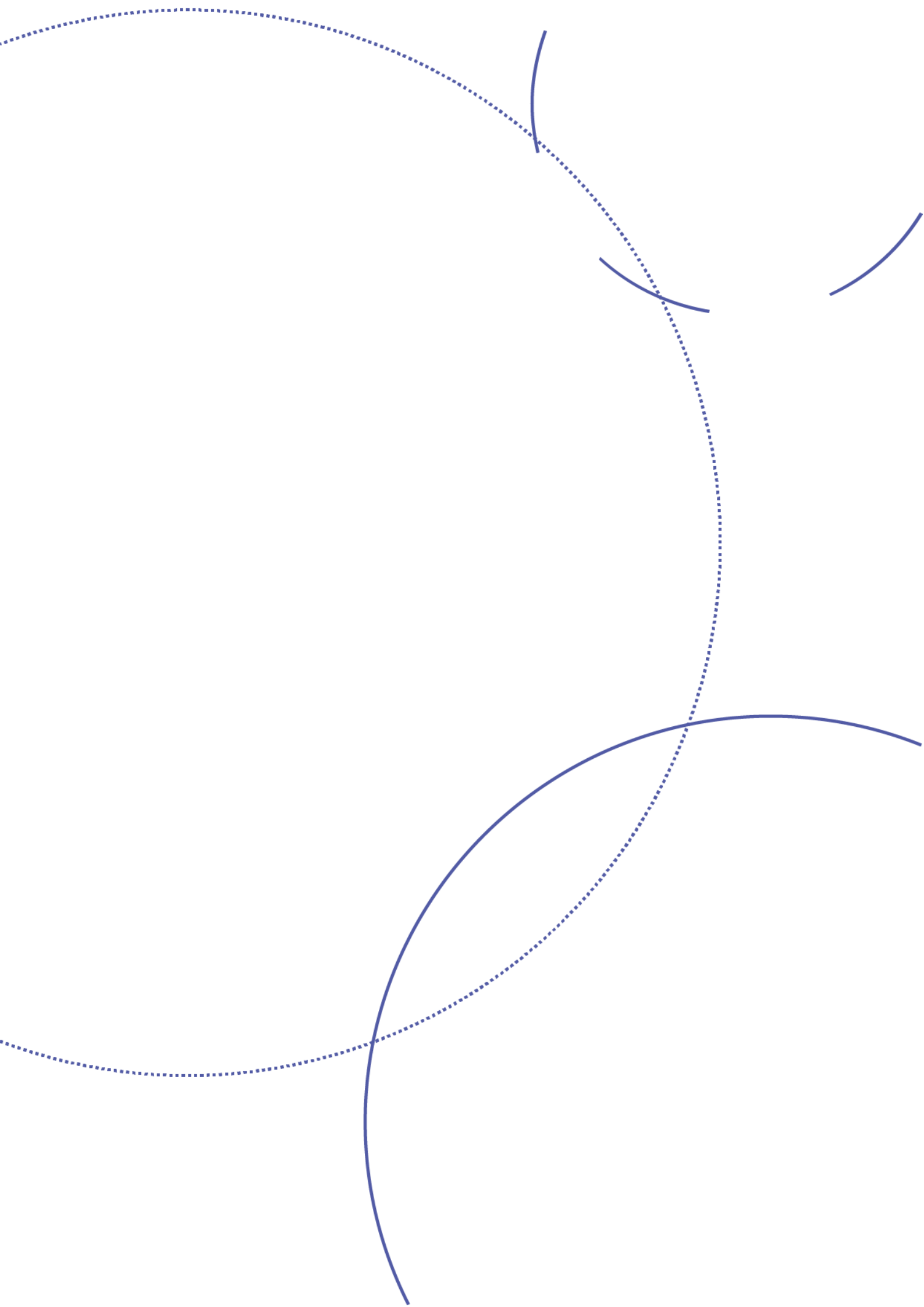
HMICS Custody Inspection Report - Fife

March 2024

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND
Improving Policing Across Scotland



HM Inspectorate of Constabulary in Scotland

HM Inspectorate of Constabulary in Scotland (HMICS) is established under the Police and Fire Reform (Scotland) Act 2012 and has wide ranging powers to look into the '*state, effectiveness and efficiency*' of both the Police Service of Scotland (Police Scotland) and the Scottish Police Authority (SPA).[1]

HMICS has a statutory duty to inquire into the arrangements made by the Chief Constable and the SPA to meet their obligations in terms of best value and continuous improvement. If necessary, it can be directed by Scottish Ministers to look into anything relating to the SPA or Police Scotland as they consider appropriate.

Healthcare Improvement Scotland (HIS) is the national improvement agency for health and social care. It is responsible for supporting healthcare providers to deliver high quality care and scrutinising those services to provide public assurance about the quality and safety of that care.

This inspection was undertaken by HMICS in terms of Section 74(2)(a) of the Police and Fire Reform (Scotland) Act 2012 and is laid before the Scottish Parliament in terms of Section 79(3) of the Act.

[1] Legislation, Police and Fire Reform (Scotland) Act 2012, Chapter 11.

Contents

Our inspection

During the course of 2022, HM Inspectorate of Constabulary in Scotland (HMICS) and Healthcare Improvement Scotland (HIS) collaborated on a baseline review of the provision of healthcare services to police custody centres across Scotland. A report outlining our findings and recommendations was published in January 2023.[2] The learning from the review has been used to support HIS to develop an interim framework to inspect healthcare services within police custody,[3] and for the scrutiny partners to devise a methodology for the joint inspection of police custody centres.

As part of this overarching review, it was agreed that we would undertake two joint custody inspections in order to continue to develop inspection methodology and to complete our inspection framework. We initially inspected and published reports relating to primary custody centres in Lanarkshire and then Tayside, the report on which was published in July 2023.[4] The third inspection, was undertaken in the Dumfries and Galloway region, focussing on primary custody centres in Stranraer and Dumfries and was published in November 2023. The fourth joint inspection, to which this report refers, was undertaken in Fife and relates to the custody centres in Dunfermline and Kirkcaldy.

The inspection was carried out jointly by HMICS and HIS, the aim of which was to assess the treatment of, and conditions for, individuals detained at the custody centres. Healthcare in the Fife custody centres is delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service which is hosted and managed by NHS Lothian. This report will provide an analysis of the quality of custody centre operations as well as the provision of healthcare services in the custody centres and consequently makes recommendations for both Police Scotland and the HSCP.

[2] HMICS and HIS, National baseline review of healthcare provision within police custody centres in Scotland, 31 January 2023.
[3] HIS, Framework to Inspect healthcare provision within police custody centres – interim version, 17 October 2022.
[4] HMICS, Custody Inspection Report – Tayside, 20 July 2023.

While recommendations outlined in this report have specific relevance for Dunfermline and Kirkcaldy custody centres, we recognise that some of these will be equally applicable to other custody centres across Scotland and should be considered in future improvement planning by Police Scotland's Criminal Justice Services Division (CJSD). We consider recommendations 5 and 6 from this report to have such relevance.

In the course of this inspection, we have found common themes that featured as recommendations or areas for improvement in the aforementioned reports on custody services in Lanarkshire, Tayside and Dumfries and Galloway. We have referenced these within the body of this report where relevant.

The onsite stage of the inspection took place in October 2023. As part of our inspection, we reviewed the Police Scotland National Custody System (NCS) and examined a representative sample of detainees processed at the custody centres during August 2023. We assessed the physical environment, including the quality of cells, and observed key processes and procedures relevant to police custody operations. We also spoke with people detained at the custody centres during our inspection and interviewed custody staff and healthcare professionals during our visit.

This report highlights our concerns regarding the recording of information on the National Custody System. We found omissions in relation to the recording of searches, cell visits, provision of food and drink, contact with reasonably named persons, issue of medicine and washing. It is unclear if these gaps in recording reflect poor and inconsistent practices or poor recording. However, we cannot be confident that these activities were taking place consistently.

As a result of our review of NCS records, we have highlighted concerns regarding the incongruence between some of the risk assessments undertaken and the corresponding care plans put in place. In addition, this report raises concerns regarding the physical layout of the centres and a lack of facilities to support the delivery of effective care and welfare for detainees.

We have been informed that some months after our onsite inspection, a person died at the custody centre in Kirkcaldy in January 2024. We are advised that the incident is being investigated as required by the Police Investigations & Review Commissioner and that the Crown Office and Procurator Fiscal Service has been notified as a fatal accident inquiry is mandatory in respect of a death in custody. It would not be appropriate for us to comment further on the circumstances of this while investigations are taking place.

Police custody has been subject to considerable scrutiny by HMICS since Police Scotland was established. Since 2013, HMICS has published several custody inspection reports, the findings from which can be found on our website.[5] Police Scotland has made significant progress in implementing previous recommendations and improvement actions in respect of custody services and is actively working to address those that remain outstanding.

Our inspection contributes to the United Kingdom's response to its international obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by a National Preventive Mechanism (NPM), an independent body or group of bodies which monitor detainee treatment and conditions. HMICS is one of several bodies making up the NPM in the UK. [6]

We wish to thank the officers and staff of the Criminal Justice Services Division of Police Scotland and Southeast Scotland Police Custody Healthcare and Forensic Examination Service staff for their assistance during our inspection.

The inspection was carried out by Ray Jones, Lead Inspector at HIMCS, with support from HMICS Associate Inspectors and HIS inspectors.

Craig Naylor
His Majesty's Chief Inspector of Constabulary
March 2024

[5] Our custody inspection reports are available on our website at HMICS.
[6] For more information about the UK NPM, visit National Preventive Mechanism.

Key findings

- The custody centres at Dunfermline and Kirkcaldy had a similar single-story layout containing multiple cell corridors and facilities. Their general physical condition was good, however, forming an older part of the overall custody estate, both centres, particularly Kirkcaldy, exhibited design aspects which present functional challenges to staff and detainees alike. Both centres were clean and reasonably well maintained.

- The rear yard at both locations served as a vehicle dock for the custody centres. Dunfermline's doubled as general operational parking and was not secured. Kirkcaldy's was protected by a remotely controlled electronic keypad roller shutter covered by CCTV viewable from the custody office.

- The air conditioning facilities for both centres were described as being very poor during warmer months with the interview rooms and staff office being particularly affected.

- The cells in both centres were clean, tidy and featured natural light sources. All except the observation cells had a dual light setting, however in Kirkcaldy this could only be controlled from the charge bar area.

- In Dunfermline it was noted that the low-level sleeping plinths incorporated two air vents comprised of multiple 1.5 cm diameter holes on their front cover. The dimensions of the holes in these unguarded vents exceed the permitted dimensions and therefore present a potential ligature hazard.

- There were no washbasins within cells and no shower facilities at either centre. Instead, each main cell corridor was equipped with a single or double sink located in or adjacent to the central corridor affording limited access to discrete facilities for washing.

- Detainees interviewed were complimentary about custody staff and stated that custody centres were generally clean and suitable, however negative feedback was received regarding the washing facilities.

- Despite dual corridors in each centre affording the capability for appropriate segregation, this approach would appear to only be used in exceptional circumstances.

- Neither custody centre had a holding room. Detainees were instead required to wait within custody vehicles parked outside the centre, which has anecdotally resulted in discomfort and agitation in detainees, particularly when processing times are extended.

- At the time of the inspection, eight cells within Dunfermline and all cells within Kirkcaldy were equipped with ceiling mounted CCTV facilities linked to the main office, providing suitable opportunity for detainee observation. HMICS has been informed that since the inspection was conducted, all cells within Dunfermline are now equipped with CCTV.

- Detainee CCTV viewing facilities in both centres were situated in the main custody staff offices and although providing good quality coverage, their location was considered to be inappropriate due to the likely high levels of distraction, which could impede focussed and attentive viewing of vulnerable persons.

- The charge bars in Dunfermline were of unconventional design, where the hatch-like construction affords a restricted view of what is an already confined processing space, and restricts immediate physical intervention regarding the movement or handling of detainees.

- Located between the two custody blocks within Kirkcaldy was an enclosed and secure external courtyard accessible from the custody centre. This space was formerly designed and used as a detainee exercise yard, albeit this facility has not been utilised in the operational memory of existing staff.

- There were sufficient supplies of toiletries and feminine hygiene products on request and both facilities had ample stores of variously sized, standard and anti-harm clothing and bedding.

- There was sufficient, clearly visible and practically located fire safety signage, emergency lighting and materials located throughout the custody centres. All cells in both centres were equipped with smoke detectors linked to an indicator VESDA VLS panel adjacent to other fire warden instructions and equipment. The system is tested on a weekly basis.

- Both centres had posters conveying information to detainees regarding their rights and access to translation and other support services, advocacy or visitors.

- There were adequate custody staffing levels at the time of our inspection. We observed a good balance of male and female custody staff at both centres.

- Custody staff, including supervisors, stated that they had received appropriate basic training including ICT access and had undertaken multiple placements at other custody centres. They stated they had also undertaken additional training for vulnerable persons, children at risk and human trafficking.

- Regarding the recording of information on the National Custody System, we found omissions in relation to the recording of searches, cell visits, provision of food and drink, contact with reasonably named persons, issue of medicine and washing.

- In the data sample examined by inspectors, there were examples where the care plan appeared to be at a lower level than the risk assessment would suggest was appropriate. In 47% of cases where the risk assessment was recorded as high, the care plan was set to level 1 or standard observations. Rationales to support those decisions were consistently absent from custody records.

- Staff at both custody centres has been provided with electronic tablets to carry out contemporaneous recording of detainee observations and interactions, however have yet to make use of this recently acquired equipment.

- At the time of the inspection, no specific human rights-based training had been provided to healthcare staff to support the effective investigation and documentation of any torture or other ill-treatment, such as on the Istanbul Protocol. This training has since been delivered via the National Police Care Network.

- There was no visible information about how a detainee could make a complaint regarding medical treatment and there had been no complaints submitted within the past year.

- There was no formal programme of audit regarding the custody healthcare service with healthcare senior management overview in place to monitor and evidence practice to help drive improvement. Inspectors found out of date medication during the inspection.

- Healthcare staff are responsible for cleaning the surfaces and clinical wash hand sinks in the treatment rooms, while the cleaning of the floor was the responsibility of an external cleaning company. Cleaning staff informed us that they were not provided with a chlorine-based product for cleaning sanitary fittings in the custody area.

- There was no infection prevention control (IPC) lead for the custody centres in Dunfermline and Kirkcaldy. There was no secure area for storing filled clinical waste.

- NHS Lothian recently appointed a pharmacist with responsibility for overseeing the governance of medicine management in the custody centres in the Southeast cluster which includes Dunfermline and Kirkcaldy. We consider this to be good practice.

- Harm reduction interventions were available to detainees with some nurses trained in motivational interviewing, alcohol brief interventions and low intensity psychology interventions.

- The custody centres refer detainees who consent to a support project known as '*Navigators*' whose members visit the custody centre each Sunday afternoon and apply lived experience in order to directly support and assist detainees.

- Take home nasal Naloxone kits were available and there was evidence of these being offered to patients.

Recommendations

Recommendation 1

Police Scotland should create a secure holding area for detainees at the custody centres.

Recommendation 2

Police Scotland should examine options to create a more effective charge bar at Dunfermline custody centre to improve booking-in processes, engagement with detainees and mitigate risks.

Recommendation 3

Police Scotland should make improvements to the location of the CCTV viewing facilities at the centres to reduce the likelihood of distraction.

Recommendation 4

Police Scotland should take steps to either remove or make safe floor level air vents in cells at the Dunfermline custody centre, which in their current state present a ligature risk.

Recommendation 5

Police Scotland should ensure that risk is correctly evaluated, addressed and recorded to ensure a clear correlation between risk assessment and care plans.

Recommendation 6

Police Scotland should ensure that improvements are made to the quality and consistency of record keeping at the centres.

Recommendation 7

Police Scotland should examine the potential for shower installation at the centres to provide appropriate washing facilities for detainees.

Recommendation 8

NHS Lothian should ensure that information about how to make a complaint is visible and shared with patients.

Recommendation 9

NHS Lothian should introduce a regular programme of audits to assure themselves and the public of the quality and safety of healthcare delivery.

Recommendation 10

Police Scotland should ensure that chlorine-based cleaning products are available for cleaning in line with national guidance.

Recommendation 11

Police Scotland should identify an area where clinical waste and sharps bins can be stored securely until they are collected.

Recommendation 12

NHS Lothian should ensure that an Infection Prevention and Control lead for custody centres is identified and that external assurance visits are implemented.

Recommendation 13

NHS Lothian must ensure that a robust date checking procedure is in place to identify medicines approaching expiry date.

Recommendation 14

NHS Lothian must ensure that detainees receive their OST treatment as prescribed when transferring to court or on liberation from custody.

Recommendation 15

Police Scotland should examine the extent to which local policing may at times use custody as an alternative to identifying an appropriate place of safety, and address any issues identified.

Areas for improvement

Areas for improvement	Number
The custody centres should introduce additional measures to further mitigate the impact of a lack of a functioning air conditioning system.	1
The custody centres should routinely consider the use of separate cell corridors for gender-based segregation to improve privacy in accessing existing washing facilities.	2
The custody centre should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.	3

Context

1. Custody is delivered throughout Scotland by the Police Scotland Criminal Justice Services Division (CJSD). This division is one of several national divisions which sit alongside and support the thirteen local policing divisions. CJSD is led by a Chief Superintendent who reports to an Assistant Chief Constable and in turn, to the Deputy Chief Constable for local policing. Custody is delivered in accordance with the custody standard operating procedure,[7] which is updated and amended regularly to reflect changes in practice guidelines and expectations.

2. While custody throughput volumes have been in steady decline since the implementation of the Criminal Justice (Scotland) Act 2016 (the 2016 Act),[8] the last financial year saw a slight increase. Table 1 below, outlines Police Scotland's annual custody throughput figures from 2018-19 to 2022-23. There are a variety of contributory factors for the previous reduction in throughput over recent years. This can, in part, be attributed to Police Scotland's proactive approach to divert people away from custody centres when it is considered safe and appropriate to do so. However, the moderate 3.5% increase in national custody throughput for the period 2022-2023, could be attributed to a post-pandemic return to more routine and expected operational practice in policing. Current throughput figures remain considerably lower than pre pandemic levels.

3. Custody centres in Scotland are organised into clusters, each led by a Cluster Inspector. The custody centres we visited during this inspection, Dunfermline and Kirkcaldy police custody centres, serve their respective Sheriffdom areas in the wider Fife area. Northeast Fife is a policing area within Fife division but falls within the Sheriffdom of Dundee. Detainees from this area can be taken to both Kirkcaldy and Dundee. Both centres are located within the local area police stations.

[7] Police Scotland, Care and welfare of persons in police custody Standard Operating Procedure, 2022 – Private item.
[8] Legislation, Criminal Justice (Scotland) Act 2016.

4. The overall cell capacity at Dunfermline is 18 cells and Kirkcaldy has 15 cells. The cell provision is considered suitable to meet demand. The annual throughput from April 2022 to March 2023 at Dunfermline was 2682 and at Kirkcaldy it was 3250. When considering the total throughput across both centres, these figures are almost unchanged from those recorded for the year before (see table 2).

5. The cluster also includes an ancillary custody centre based in Levenmouth. Ancillary centres are not routinely staffed but can be opened by trained staff as and when required. The ancillary centre was outwith the scope of this inspection and therefore not visited by inspectors.

6. Healthcare is delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service which is hosted and managed by NHS Lothian. Healthcare is provided peripatetically. Daily staffing for the Southeast consists of three clinical forensic nurses (CFNs) and one advanced nurse practitioner (ANP) working on day shift and four CFNs and one ANP working night shift. Two Forensic Physicians are on call for both day and night shifts. Senior charge nurses (SCNs) work Monday to Friday.

7. At the time of our inspection, Dunfermline was staffed with a sergeant and a Criminal Justice Police Custody Security Officer (CJPCSO). This was described as unusual, as the centre would typically have two members of staff supporting a sergeant. With only one CJPCSO, they set a maximum limit of ten detainees although there were just three detainees during our visit. Staff appeared able to fulfil all of their functions. At Kirkcaldy there was a sergeant with a custody constable and two CJPCSO's. No local policing officers were deployed in a custody role at the time of our inspection. We observed a good balance of male and female custody staff at both centres.

8. Each staff team at Dunfermline was made up of a police sergeant (PS), a CJPCSO team leader, a custody constable and two CJPCSO staff. Each team at Kirkcaldy was made up of two police sergeant's and two CJPCSO's. At the time of the inspection, two of the team leader posts were vacant and staff on those teams reported to the sergeant. Efforts were underway to progress recruitment of team leaders. One of the five constables was based at Kirkcaldy rather than Dunfermline although there was no apparent reason for this.

9. In terms of budgeted posts, Kirkcaldy has two sergeants per team, Dunfermline has one sergeant and one team leader per team. The team leader line manages CJPCSOs at both centres but is seldom able to visit staff at Kirkcaldy and has no input on operational decisions, which fall to the sergeant. The absence of two team leaders appeared to have little impact on those teams. An absent team leader is never covered, and in these circumstances, sergeants assume responsibility. Some teams have no team leader and sergeants therefore assume all responsibility. Despite the team leader being responsible for care and welfare, the initial decision must also be agreed by the sergeant, which introduces split responsibilities. We commented on the importance of ensuring clarity regarding the role of custody supervisors in our joint custody inspection report on Tayside and recommended that:

"clear lines of accountability are defined and stipulated for custody supervisors in the event of an adverse incident resulting in serious harm to a detainee."[9]

10. At the time of our inspection, all staff observed the CJSD 222b[10] shift pattern.

Table 1 – National custody throughput

Year	2018-19	2019-20	2020-21	2021-22	2022-23
Throughput	118,418	115,126	101,203	93,967	97,381

Table 2 – Custody centre cell capacity and throughput

Custody centre	Number of cells	2021-22	2022-23
Dunfermline	18	3077	2682
Kirkcaldy	15	2875	3250
Total	33	5952	5932

[9] HMICS, Custody Inspection Report – Tayside, **Recommendation 2**, 20 July 2023.
[10] The CJSD 222b pattern relates to custody staff working two early shifts, two late shifts and two nights, followed by four non-working days.

Independent custody visitors

11. Under the Police and Fire Reform (Scotland) Act 2012,[11] the Scottish Police Authority (SPA) is required to make arrangements for independent custody visitors to monitor the welfare of people detained in police custody. Regular visits to custody centres are carried out by volunteer independent custody visitors from the local community. Independent Custody Visiting Scotland (ICVS) manages the process and coordinates volunteers. Any concerns identified by custody visitors are raised with custody staff during their visits and outcomes are recorded in custody records. ICVS is also a member of the UK's NPM.

12. During our inspection, we reviewed the ICVS service book that is completed following each visit by the custody visitors. This reflected a pattern of recent and regular visits with no issues raised.

[11] Legislation, Police and Fire Reform (Scotland) Act 2012, Chapter 16.

Methodology

13. HMICS and HIS undertook a wide range of activities during our joint baseline review of healthcare provision in custody to inform the development of our custody inspection methodology. These activities are outlined in the aforementioned joint report published in January 2023.[12] As a result, the following key stages have been undertaken for this inspection and will from a basis for future joint inspections.

14. In advance of the onsite inspection, we requested information on throughput at the custody centres in order to analyse a sample of this on the Police Scotland National Custody System (NCS).

15. HIS requested key pieces of evidence in advance of the onsite inspection relevant to healthcare provision. On the first day of the inspection, HIS also issued a letter to the NHS board to request a follow-up meeting with NHS managers to enable the inspection team to discuss key issues arising from the onsite inspection and the evidence review.

16. Inspectors from HMICS and HIS visited the custody centres at Dunfermline and Kirkcaldy between 2nd and 8th October 2023. During the custody inspection, we examined the treatment of, and conditions for, detainees. We observed key custody processes and assessed the custody environment, condition of cells and facilities for detainees. We undertook interviews with custody staff and managers, as well as healthcare practitioners (HCP) that were present during our visit. We also spoke with people detained in custody at the time.

17. A proportional sample of custody records were examined from those created in Dunfermline and Kirkcaldy during the month of August 2023. Of the 466 records during that period, 203 related to persons processed at Dunfermline and 263 at Kirkcaldy. We examined 46 records, 19 from Dunfermline and 27 from Kirkcaldy, which represents a 10% sample.

[12] HIS, National baseline review of healthcare provision within police custody centres in Scotland, 31 January 2023.

18. The sample was selected to be broadly representative of the proportions of men, women and children held in custody during the aforementioned period. Based upon this, sampling was weighted to ensure that women and children were included during random selection.

19. The review of NCS records provided valuable information on aspects of risk assessment, observation levels, and compliance with the expectations of the Police Scotland care and welfare of detainees, standard operating procedure.

Outcomes

Custody centre condition and facilities

20. The custody centres at Dunfermline and Kirkcaldy were incorporated into the footprint of existing operational police stations. Both had single story layouts containing two separate charge bars, two cell corridors comprising of 18 and 15 cells respectively and housing related facilities for detainees as well as adjacent administration, criminal justice, catering and storage spaces.

21. We examined the route into both custody centres, the confines of which were suitably protected by CCTV systems linked to respective staff offices. Dunfermline was accessed via a lane leading from the public parking area at the front of the station and is not secured by any form of closure or gate. The limited parking area was also utilised by operational police vehicles.

22. Kirkcaldy featured a secure, custody only, enclosed rear yard protected by a roller-shutter, which was accessed via a lane from the public road. Accommodation space for detainee transport was very limited at both centres, only affording sufficient space for car or van sized custody vehicle. Larger vehicles were required to park in the lanes or in the case of Kirkcaldy, the public road and detainees walked into the centres. Both rear yards were tidy and free from unnecessary clutter.

23. Access to Dunfermline custody suites was on the same level, however access to Kirkcaldy was via a flight of steps with no ramp available. This was acknowledged by staff who indicated that any detainees with access requirements would be re-directed to an appropriate custody centre.

24. Neither custody centre had a holding room. Detainees were instead required to wait within custody vehicles parked outside each centre, which impacted detainee wellbeing and disposition particularly during extremes in outside temperature. Interviews with staff and local policing conducted during this inspection established the absence of an appropriate holding area to be a source of frustration for operational officers who also cited instances where detainees have been required to wait in inclement conditions, resulting in discomfort and occasional disruptive behaviour.

Recommendation 1

Police Scotland should create a secure holding area for detainees at the custody centres.

25. Both custody centres had two charge bars containing suitable IT facilities and other materials to facilitate efficient processing of detainees and facilitate the operation of a discreet charge bar should it be required.

26. One charge bar in Kirkcaldy was elevated, the other being a floor level workstation separated by a Perspex safety screen.

27. The charge bars in Dunfermline however, were somewhat unconventional in that their construction consists of a three by two foot partially screened opening in the wall. This hatch like design afforded a limited view of what is an already restricted processing area.

28. Inspectors observed the booking-in of a detainee during which the hatch design, coupled with the off-set positioning of the workstation, was clearly seen to impede communication as the operator required to constantly re-position and lean into the aperture to effectively interact with both the detainee and officers during what are crucial initial stages of information gathering and risk assessment. Furthermore, the enclosed space offered no immediate access to the processing space, should physical intervention be required in the movement or handling of detainees.

Recommendation 2

Police Scotland should examine options to create a more effective charge bar at Dunfermline custody centre to improve booking-in processes, engagement with detainees and mitigate risks.

29. Detainee property storage at both centres was provided by way of lockable floor mounted steel lockers used for storing bagged and tagged custody property that is routinely handled on the charge bar. While these areas are covered by rear located CCTV and microphones, neither centre had overhead cameras for unobscured recording of detainee property handling.

30. As outlined in our report on the joint inspection of primary custody centres in Tayside, we highlighted areas for improvement that have relevance across the custody estate. One such observation from that report related to the safe handling and secure storage of detainee's personal property, which states:

"The custody centre should ensure that property handling guidance and practice is followed to avoid property challenges."

While this has relevance for Dunfermline and Kirkcaldy custody centres, we do not intend to stipulate a further area for improvement in this regard.

31. In Dunfermline the main charge bar corridor afforded access to additional facilities such as the well-appointed medical examination room, a single staff only toilet, storeroom and two (separated) detainee access rooms, one being used as a store. Opposite the entrance door was a keypad controlled connecting door leading to the wider station via a further corridor which housed the photograph/impressions intoximeter room, DNA storage, double interview suite and kitchen.

32. In Kirkcaldy, the initial processing area provided secured access via a short flight of stairs to the adjacent Sherrif Court building. To the right of the initial processing were the medical room, storage spaces, larger (primary) charge bar and cells complex. The smaller of the two cell corridors also led to a set of stairs affording access to two spacious but otherwise unused detainee engagement rooms.

33. The charge bar area also provided access via a secure door to the main police station and connecting corridor where the custody staff office, kitchen, print, intoximeter and interview rooms were located.

34. Both custody centres had well-appointed kitchens which were spacious, tidy, hygienic and contained a variety of appropriate foodstuffs and suitable food hygiene and preparation guidance.

35. In Dunfermline, the main staff office could be accessed midway along the charge bar corridor via two sets of unsecured doors. The office was very spacious, tidy and well-appointed offering five workstations for custody staff including co-located front counter staff. This staff office afforded access to the main charge bar and public counter area and also housed a partitioned space housing screens for detainee CCTV monitoring. A whiteboard was clearly visible and used for relevant detainee care and welfare notes.

36. In Kirkcaldy, the main staff office was accessed via the corridor connecting the suite to the station via a single keypad-controlled door. The office, which also afforded access to the neighbouring kitchen, was more cramped than at Dunfermline as it accommodated six workstations for custody staff, CCTV observers and co-located front counter staff. The office was tidy and well-appointed and contained suitably positioned and universally visible CCTV viewing screens. A whiteboard was also clearly visible and used appropriately at this location.

37. Interview rooms at both centres were lit with artificial lighting only and contained a secured interview desk with hygiene screen and unsecured chairs. The rooms were not covered by the custody CCTV system, however did have linked affray strips fitted. Although spacious, the rooms were poorly ventilated. The placement of conventional fans did little to improve ventilation, which local officers stated requires frequent and disruptive comfort breaks during interviews in warmer months.

38. Overall, the air conditioning systems serving both facilities were described by staff as being '*very poor*' with staff offices also being affected due to the inability to open windows for security reasons. In Kirkcaldy, the poor functionality was attributed to a broken air flow system which has been non-operational for a considerable period due to the inability to source obsolete parts and prohibitive cost of a total replacement. While some mitigating measures were in place, by way of desk-top fans, these were largely ineffective

Area for improvement 1

The custody centres should introduce additional measures to further mitigate the impact of a lack of a functioning air conditioning system.

39. The CCTV detainee observation facilities at both centres were not considered to be fit for purpose due to their location within the main custody offices. At Dunfermline the screen was located in the corner of the office separated by a low partition, which did not fully isolate the observer. In Kirkcaldy the CCTV viewing function is incorporated into the centrally located bank of workstations with no separation.

40. The location of both viewing facilities in an active and often busy office environment, which is also shared by public counter staff, meant those performing CCTV observations were subjected to significant levels of distraction which could impede focussed and attentive viewing of vulnerable persons. These concerns were also voiced by local officers and supervisors, who considered this to represent an unnecessary risk to detainees under observation and to officers expected to maintain high levels of focus often for protracted periods. As such, alternative arrangements should be made for the location of the CCTV observation facilities to ensure staff undertaking observations are suitably separated from unnecessary distraction.

Recommendation 3

Police Scotland should make improvements to the location of the CCTV viewing facilities at the centres to reduce the likelihood of distraction.

41. There was sufficient, clearly visible and practically located fire safety signage, emergency lighting and safety materials located throughout the custody centres. All cells in both centres were equipped with smoke detectors linked to an indicator VESDA VLS panel[13] adjacent to other fire warden instructions and equipment. The system is tested on a weekly basis.

[13] VESDA VLS is an early warning smoke detection system, which uses continuous air sampling to provide the earliest possible warning of an impending fire hazard.

42. There was ample storage space at both centres and all areas were tidy, well ordered and contained appropriately stored materials.

43. Staff were not issued with personal alarms, however most wall surfaces within both custody centres, adjacent rooms and access corridors are fitted with '*affray alarm*' panels. These highly visible strips, though relatively few in number and in less prominent locations than have been observed at other custody centres, still afford ample opportunity for raising the alarm.

44. All staff routinely wear appropriate PPE for control and restraint but did not routinely carry ligature cutters, albeit these items were available for use in the charge bar and staff offices at both centres.

45. There were clearly marked emergency exits within the custody footprint. Fire safety precautions and procedures were taking place routinely. While fire tests were being carried out regularly, these have not yet included physical evacuation of detainees. An evacuation of custody centres, including detainees, has been planned by supervisors and was scheduled to be carried out in accordance with fire safety regulations. The custody centres have the autonomy to decide when it is suitable to do this based on an assessment of risk and the needs of the detainees in custody at any given time. There was an appropriate supply of rigid handcuffs for the evacuation of detainees stored at both centres.

46. The general condition of the custody centres was good, despite both, particularly Kirkcaldy, forming an older component of the custody estate. There was evidence of minor damage to some parts of the buildings, however these instances were documented and subject of appropriate remedial action by staff.

Condition of cells

47. The cells complex at Dunfermline comprises 18 cells, two of which are designated as direct observation cells owing to their toughened glass panel doors. All cells were operational on the day of inspection.

48. The cell complex at Kirkcaldy comprises 15 cells. Two cells were non-operational on the day of inspection owing to a minor mechanical issue and a cleaning requirement, both of which were being addressed appropriately.

49. Eight cells in Dunfermline and all 15 cells in Kirkcaldy were equipped with ceiling mounted CCTV which afforded unobstructed views of the entire cell. The footage from the in-cell CCTV is routed to both the charge bar and custody office, where it could be viewed in various configurations on monitoring screens.

50. Cells in both centres had low-level sleeping plinths. In Dunfermline, inspectors noted the low-level sleeping plinths incorporated two, foot-long front facing ventilation panels, which comprised multiple 1.5 cm diameter holes. These vents require frequent unblocking by staff to remove miscellaneous items lodged within the vent holes by detainees. More significantly, the dimensions of the holes in these unguarded vents exceed the maximum recommended allowance of two millimetres for internal cell ventilation apertures and therefore present a potential ligature hazard to detainees. This was raised with and acknowledged by supervisory staff and managers at time of our inspection.

Recommendation 4

Police Scotland should take steps to either remove or make safe floor level air vents in cells at the Dunfermline custody centre, which in their current state present a ligature risk.

51. Most cells at both centres were found to contain thick mattresses, and some thinner, but nonetheless compliant in design. All bedding was in good condition, however no pillows were available.

52. Every cell contained a single call button situated away from the sleeping plinth above the toilet. Call buttons were linked to the charge bar and staff office but had no intercom facility. Cell call buttons were tested and found to be fully functional and capable of being de-activated in the event of misuse.

53. Cells had toilets with external controlled chain operated flush only and paper supplied on demand. Dunfermline had no dry cell capability and Kirkcaldy contained one dry cell, however appropriate devices were available to seal cell toilets and render the cell *'dry'* if required.

54. Cells in both centres were well lit by artificial lighting and glass brick wall sections providing natural light. In both centres lights have dual settings, although in Kirkcaldy these could only be controlled from the charge bar area introducing unnecessary journeys when managing detainee requests. At the time of inspection, the CCTV at Dunfermline was not fitted with infrared technology to allow for viewing in low light, however it is understood that a new CCTV system with infrared capability has since been installed.

55. Both centres featured older style slam locking cell doors with peep holes and two position service hatches. The dimensions of the cell doors in Kirkcaldy, owing to the centres 19th century construction, were notably small being approximately 2ft wide by 5ft 8 inches tall. This comparatively restricted access height is highlighted to detainees and staff alike by way of prominent yellow and black chevron markings on the exterior lintel of each cell door.

56. There were no accessible cells within either facility and therefore none of the cells were fully compliant with current equality legislation[14] in respect of accessibility for people with mobility challenges. Staff stated that when a detainee has accessibility requirements, consideration is given to conveying them to the most suitable and appropriate custody centre, based on availability, distance and identified needs.

57. Despite the custody centres being within an older part of the custody estate, cells were largely in good order, functional and regularly cleaned.

[14] Legislation, Equality Act 2010.

Arrival at custody and booking-in process

58. During the inspection, we observed five detainees being booked into custody. In all instances, staff were thorough and professional. They built a good rapport with detainees and were respectful. In each case, staff at the custody centre received advanced notification of detainee particulars from arresting officers either by telephone or radio to enable the commencement of background checks. Custody staff checked PNC, CHS, the national custody system, iVPD,[15] and legal documents to check for warrants and citations. The information gathered helped to inform the initial risk assessment and enabled swifter processing. We consider advance checking of antecedent information to be good practice.

59. When detainees arrived at the custody centres, one officer remained with them in the police vehicle while the other officer entered the custody centre to discuss the circumstances with the sergeant. This was to afford sufficient information to allow the sergeant to authorise the arrest. However, this can introduce an element of risk while the detainee remains in the vehicle with one officer due to the absence of a waiting or holding area.

60. In our examination of the NCS, we found that the recording of a sergeant's authorisation of arrest was generally acceptable with some exceptions. One record omitted any authorisation until prompted by the custody review inspector at the six hour review stage and another lacked a rationale for a court custody decision.

61. We assessed the average waiting time relevant to the booking-in process during our review of NCS records. The average time of waiting within the sample was 15 minutes. This figure compares favourably with the national average which is 26 minutes although is five minutes longer than that found in our most recent inspection at Dumfries and Stranraer.

[15] Police information systems include the Police National Computer system (PNC), Criminal History System (CHS), and interim Vulnerable Persons Database (iVPD).

62. Detainees were managed in a proportionate and respectful manner by arresting officers under the guidance of custody staff. Searches were safe, methodical and respectful with officers routinely using handheld metal detectors and '*Ampel*' probes (large tweezers), which were available from the charge bar. It was notable at Dunfermline however, that the serving hatch style of charge bar impeded the ability of custody staff to adequately supervise the search. It also hampered conversation between the custody staff member and the detainee.

63. Of the 46 records we examined on the NCS, we found that 8 (17%) detainees were strip searched and each was appropriately authorised. There was no record of any search in 6 (13%) of the records. Inspectors felt that it was very unlikely that a detainee was not searched, and this was likely to have been a recording error.

64. The detainee's we observed being processed at Dunfermline did not have property taken as they were escorted directly to interview with an anticipated release shortly thereafter. Staff explained that when property is taken it is handed over the counter, logged onto the NCS, sealed in a bag and placed in a locker in the charge bar office. At Kirkcaldy, property was placed onto the counter by the arresting officer. It was logged on the NCS and sealed within a bag in the presence of the detainee before being placed in a locker behind the charge bar. The property lockers at both centres were in staff only areas and are covered by CCTV, though none were locked.

65. Custody staff were responsible for taking criminal justice fingerprints and DNA samples from detainees and these tasks were undertaken at the earliest opportunity, demonstrating an efficient use of time. In cases where evidential fingerprints or DNA are required, it is the responsibility of the investigating officer to obtain, store and submit them for analysis. Custody staff were also responsible for completing Nexus[16] checks in relevant cases. Related processes observed during our inspection were undertaken efficiently and effectively.

66. Inspectors returned on a Sunday evening to speak with detainees that had been held for over 24 hours in order to more fully assess their experience in custody. Overall, the feedback received was very positive, with detainees highlighting that they had been treated well and that staff had been attentive.

[16] Operation Nexus is a joint initiative between the Home Office and Police divisions across the UK to verify the immigration status of, and gather information from, foreign nationals, including EEA nationals.

Legal rights

67. During onsite observations, detainees were informed of their rights while they are in custody and offered a letter of rights reinforcing this information. Mandatory fields on the NCS custody system ensure compliance with this legal obligation and our examination of NCS records confirmed that all detainees in the sample were offered a letter of rights.

68. From our examination of custody records, we found that a Police Interview – Rights of Suspects (PIRoS) form had been completed appropriately for all detainees. Contact with a solicitor was requested in 20 cases and was complete in all but one case, where there was no record to indicate if it was completed. A reasonably named person was requested on 15 occasions and contact was made in all but one instance where the record showed that there was difficulty in tracing that person. However, there was no comment to explain if this was followed up or resolved.

69. An interpreter was noted as being required in three cases. There was no record to indicate that a translation service had been engaged. Again, this is likely to be an omission in recording rather than an absence of contact being made with the service, however we are unable to be confident that this has taken place due to gaps in the records.

70. From our examination of NCS, we found that the majority of detainees in our sample (56%) were held for less than 12 hours and 26% were held for between 12 and 24 hours. Nine percent were held for between 24 and 48 hours, and 9% for longer than 48 hours. These cases related to detainees held over a weekend for court.

71. From our sample, 52% of detainees were held for court. Thirty percent were released on undertaking, 6% on summoning report, 2% were referred to the children's reporter and 10% were released without charge. For the calendar year 2023, 43.84% of detainees from Fife were held for court, which is slightly higher than the national average of 41.77%. HMICS understands that work is ongoing within CJSD to reduce these numbers further in accordance with the legislative requirement for the presumption of liberty.[17]

[17] Legislation, Criminal Justice (Scotland) Act 2016.

Risk assessment and care plans

72. Of the 466 records from which we drew our sample of 46, there was only one record for a younger child (age 14) and 15 records for older children (16-17), and we sampled five of these. This data reflects that very few children were being brought to custody during the period examined.

73. During the booking-in process, a risk assessment is carried out for all new arrivals to police custody. Detainees are asked a range of questions by custody staff based on a pre-determined vulnerability questionnaire. The purpose of the questionnaire is to identify past or present issues in relation to physical and mental health, substance use, self-harm, suicidal ideation or other vulnerabilities. Effective risk assessment is vital to ensure that detainees can be managed and cared for appropriately. A vulnerability assessment was completed in all cases within our sample of records except one, however the individual in this case was transferred directly to hospital at admission.

74. This initial risk assessment process allows custody staff to determine a bespoke care plan for detainees and involves determining whether the person presents high or low risk and applying a corresponding level to determine the appropriate frequency of wellbeing observations. This approach is based on an assessment of threat, risk and vulnerability. Responses to the vulnerability questionnaire and the subsequent care plan are recorded on NCS. Based on the outcome of the risk assessment, detainees are subject to observations and rousing[18] in accordance with the following standardised scale:

- **Level 1 – general wellbeing observations.** For an initial period of six hours, all detainees are roused at least once every hour. Thereafter, hourly visits are still undertaken but detainees need not be roused for up to three hours. This level is suitable for detainees who are assessed as low risk.
- **Level 2 – intermittent observations.** Detainees are visited and roused at 15 or 30-minute intervals. This level is the minimum for detainees suspected of being under the influence of alcohol or drugs, whose level of consciousness causes concern or where there are other issues necessitating increased observation.
- **Level 2 – enhanced intermittent observations.** This is similar to Level 2 but with the addition of CCTV observation of the detainee in their cell, with images appearing on a monitor in the staff office. This allows for periodic checking but falls short of requiring an officer to constantly view a monitor.
- **Level 3 – constant observations.** The detainee may be under constant observation via CCTV, a glass cell door or window, or a door hatch. Visits and rousing may take place at 15, 30 or 60-minute intervals.
- **Level 4 – close proximity observations.** Appropriate for those detainees at or posing the highest risk. This involves detainees being supervised by staff in the cell or via an open cell door.

[18] Rousing involves gaining a comprehensive verbal response from a detainee, even if it involves waking them while sleeping. If a detainee cannot be roused, they should be treated as a medical emergency.

75. Of the sample we examined, 33% of detainees were intoxicated on arrival and 11% declared they were alcoholics. 50% disclosed a mental health condition and 39% reported they had previously self-harmed or had attempted suicide. 52% were on prescribed medication and 24% stated they had difficulty with reading and writing. These statistics reflect a correlation between health vulnerability and offending which is relatively consistent across the country.

76. Our review showed that 26% of detainees were considered low risk and 74% were considered high risk. In 16 (47%) cases where the risk assessment was recorded as high, the care plan was set to level 1 observations. There may be an acceptable reason for a detainee who is deemed to be high risk to be placed on standard observations, however there should be a suitable explanation and rationale to support these decisions. However, such rationales were consistently absent from custody records in these cases.

77. Within the sample, there was no use of level 2 enhanced observation or level 3 (CCTV). Only two people were placed on constant observations, one being a 14 year old child. Despite there being typical levels of vulnerability risks within the sample, most detainees were placed on standard observations.

78. In cases where level 3 or 4 constant observations are required, this duty almost always falls to local policing. The consequence is that an officer must be brought from a frontline role to do this, which can add pressure to local policing service delivery. When interviewed, a local policing officer stated they felt the requirement for constant observation duties was quite frequent although this was not evident in our review.

79. Custody staff said that the most common complaint from the Fife division related to the requirement to undertake constant observations and hospital escorts, which requires the provision of local policing officers. We were told that such decisions, made by the custody sergeant, were often challenged by Fife division. Given this and the relatively low use of enhanced observations within our sample, there appeared to be a reluctance to implement constant observations due to the impact on local policing and the subsequent complaint that can ensue.

80. In five of the cases reviewed, the observation level was changed from level 2 to level 1 following an appropriate period, however none of these were accompanied by a satisfactory rationale on the national custody system.

Recommendation 5

Police Scotland should ensure that risk is correctly evaluated, addressed and recorded to ensure a clear correlation between risk assessment and care plans.

81. Relevant information on criminal justice decisions, and in relation to care and welfare plans, should routinely be passed from one shift to another. This should be in the form of a handover briefing between sergeants or team leaders. It should be recorded on the NCS and is key to managing and re-evaluating risk. In our examination of the NCS there was no handover recorded in eight records where we considered it should have been present.

Detainee care

82. In our examination of NCS records, we found that 5 (12%) records reflected missed or late observation visits and one had more frequent visits than the care plan dictated suggesting a different plan was being followed.

83. During our inspection, we noted that staff practice was to conduct observations and note the time and response on a piece of paper before returning to the office to update the details onto the NCS. Both custody centres have been provided with hand-held electronic tablets to carry out this task, however these were not being used. It had been suggested that there was an issue with WiFi connections, however we were informed that this has been resolved. Staff should therefore be using the technology that has been provided for this function.

84. This matter has been the subject of previous HMICS recommendations where the ability to make contemporaneous records of cell checks and detainee comments using a tablet was considered best practice. **Recommendation 1** from our inspection report on custody services in North East Scotland states that:

"Police Scotland should replace the existing paper-based recording system at Kittybrewster with an effective and reliable electronic system that can be updated in real time from the location that cell checks are being undertaken."

We consider this recommendation to have relevance for practice across all custody centres.

85. In 11 (24%) records, there was no reference to the provision of food where we consider that there should have been. There were references to the provision of water or tea in free text across some records, although there was no reference to the provision of a drink in 28 (61%) of the records we examined. There were similar gaps in the recording of a wash being offered to detainees.

86. During the onsite inspection we interviewed 14 detainees across both centres. With the notable exception of one detainee's dissatisfaction with the washing facilities, the feedback was universally complimentary of officers and staff from both Fife division and CJSD. Detainees described feeling respected, having been provided with information on their rights, medical support where necessary, food and drink and most had been provided with a book to read.

87. This suggests that the findings from our review of records may reflect poor recording practice rather than deficits in staff practice, however it is difficult to draw conclusions in the absence of comprehensive records. As a result, inspectors cannot be assured that the activity was taking place as required.

Recommendation 6

Police Scotland should ensure that improvements are made to the quality and consistency of record keeping at the centres.

88. The cells at both centres have toilets with external operated flush only and paper supplied on demand. There were no washbasins within cells and more notably there were no shower facilities available at either centre. Instead, each main cell corridor was equipped with a single or double sink located at the end of the corridor, affording limited access to discrete or modest space for washing. In Kirkcaldy, one cell corridor has two sinks located in a side room accessed by two short saloon style swinging doors, again affording only limited modesty for users, however this space also doubles as a clothes store making it equally impractical for more extensive washing requirements.

89. The absence of showers is unusual in the custody setting and was described as being '*unacceptable*' by staff and one of the detainees interviewed. While it is recognised that the age and configuration of the property presents considerable challenges, efforts should be made to address this issue.

Recommendation 7

Police Scotland should examine the potential for shower installation at the centres to provide appropriate washing facilities for detainees.

90. The dual corridors in each centre enable gender or age-based segregation, however based upon staff feedback, segregation would appear only to be used in exceptional circumstances. Children were not placed in cells at the time of our inspection and are accompanied by officers within an interview room when at the station. Staff made every effort to ensure separation of children from adult detainees when at the custody centre.

Area for improvement 2

The custody centres should routinely consider the use of separate cell corridors for gender-based segregation to improve privacy in accessing existing washing facilities.

91. One cell in Dunfermline was marked with a compass/direction indicator to assist detainees and staff for prayer purposes. Kirkcaldy staff used an online compass to direct detainees. Both centres had suitably stored religious reading materials and prayer mats.

92. The kitchen stores in each centre contained a basic variety of foodstuffs providing adequate sustenance including vegetarian and vegan options. This did not include fresh fruit, however tea and drinking water was readily available.

93. There were sufficient supplies of toiletries and feminine hygiene products on request and both facilities had ample stores of variously sized, standard and anti-harm clothing and bedding.

94. The facilities had clear and suitably located multilingual posters for identifying foreign languages and translation services which could be accessed utilising a phone located at the charge bar. Both centres had suitably placed posters conveying information to detainees regarding rights, wellbeing and access to support, advocacy or visitors.

95. Custody staff stated that they had received basic training at their initial appointment for custody care and welfare, including moving and handling and officer safety. Training also included the use of ICT systems and involved multiple placements at other custody centres over a six-week orientation period, requiring them to be taken off the shift rotation until completion, which we considered to be positive practice. Staff indicated that they were not aware of training relating to substance abuse, mental health awareness or trauma informed care.

96. As outlined in our report on the joint inspection of primary custody centres in Lanarkshire, we have made recommendations that have relevance across the custody estate. **Recommendation 4** from that report stated that:

    "Police Scotland should ensure that custody staff receive regular custody update training/awareness raising relating to substance abuse issues, mental health, trauma informed care and undertaking detainee observations."

    While this has relevance for Dunfermline and Kirkcaldy custody centres, we do not intend to make an additional recommendation in this regard.

97. Inspectors were encouraged to find that some custody staff had participated in specialised training in respect of vulnerable persons and human trafficking awareness. This represents a positive step in terms of increasing overall staff awareness of relevant risk areas and helps to promote improved care and welfare for detainees.

98. Inspectors were informed that custody officers had recently received training to administer Naloxone.[19] This was delivered via an online Moodle package and reflects a positive development in terms of the expansion of staff awareness raising and training on this subject. We saw that Naloxone was available for use in the custody centres.

99. At Kirkcaldy, strip searches take place within the cell that the detainee is placed. There are no cells or areas that are not covered by CCTV and cameras are not turned off during the search. Whilst the viewing of CCTV is restricted, as monitors are either switched off or covered during a search to prevent staff not involved in the search from viewing it, detainees should be made aware of this arrangement.

100. We observed that an enclosed and secure external courtyard was accessible from the custody centre at Kirkcaldy. The facility was located between the two custody blocks within the centre and staff informed that the external space was formerly used as a detainee exercise yard. This was no longer the case and therefore no outdoor exercise space was available for detainees.

[19] Naloxone is an emergency antidote to overdoses as a result of heroin (or other opioid/opiate) use, which reverses the suppression of the respiratory system.

Healthcare

101. We found that a healthcare professional (HCP) was required in 15 (33%) of the cases reviewed in our NCS sample and in 14 of these, records indicate that a HCP was contacted. There were four further cases in which we considered a medical referral to be appropriate but there was no record of this being made.

102. Medicine was prescribed and dispensed in 8 (17%) cases and on each occasion the NCS was appropriately updated.

103. The records review identified some cases where access to a HCP assessment was not possible due to HCP availability. On occasion, this resulted in assessments for fitness for court being deferred until the following morning. We noted a similar situation in respect of a vulnerability assessment that was deferred and then not completed.

Governance of Healthcare

104. Dunfermline and Kirkcaldy custody centres sit within the NHS Fife board area. Healthcare in these centres is delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service which is hosted and managed by NHS Lothian. The service is nurse led with leadership provided by a Clinical Nurse Manager. The Southeast cluster covers other NHS boards which means healthcare is provided peripatetically and therefore is not based in a single custody centre. Healthcare staff work across the Southeast cluster 24 hours, 7 days a week and 365 days a year. Daily staffing for the cluster consists of three clinical forensic nurses (CFNs) and one advanced nurse practitioner (ANP) working on day shift and four CFNs and one ANP working night shift. Two Forensic Physicians are on call for both day and night shifts. Senior charge nurses (SCNs) work Monday to Friday 9am-5pm.

105. Any staffing gaps are escalated to the SCN in the first instance. Permanent staff would be offered extra hours or bank shifts to cover staffing gaps. At the time of the inspection, interviews were taking place for one CFN vacancy. Staffing levels were deemed to be adequate, and inspectors were informed there were generally no delays recruiting to vacant posts.

106. Twice daily staff huddles take place which enable staff to handover any outstanding patient or service issues to staff coming on duty.

107. There is no nationally agreed waiting time standard for healthcare assessment of individuals detained in police custody centres across Scotland. However, referrals made from Police Scotland to healthcare staff are triaged within one hour. Waiting times can vary depending on the nature of the assessment, the number of detainees in the various custody centres in the southeast cluster and the location of the nurses on duty. The current national electronic system for recording healthcare data (Adastra)[20] used across all custody centres in Scotland does not provide sufficient functionality to enable clinical data to be appropriately recorded, monitored and reported. As a result, reliable data for patient waiting times for access to healthcare is not available.

108. Healthcare was well managed, with NHS Lothian's Royal Edinburgh Hospital and Associated Services (REAS) providing monitoring and oversight through their clinical and care governance processes and clear management structures. The senior management team for police custody healthcare meet monthly. Southeast cluster operational meetings are also held monthly where learning from governance issues is shared with operational staff, and Police Scotland are invited to attend. Additional pathway and regional planning meetings are held where representatives from NHS Lothian, other NHS boards in the southeast cluster and Police Scotland meet to discuss custody healthcare. The Clinical Nurse Manager (CNM) informed us that they have developed links with the mental health CNM in NHS Fife to look at improving mental health pathways for patients in police custody.

109. New staff receive induction training which includes orientation to each of the custody centres. The induction also introduces staff to trauma-informed practice. Staff are required to complete NHS Lothian mandatory training in addition to specific training required for their roles. At the time of the inspection, no specific human rights-based training had been provided to healthcare staff to support the effective investigation and documentation of any torture or other ill-treatment, such as on the Istanbul Protocol. However, we are aware that such training has since been delivered via the National Police Care Network.

[20] Adastra is an IT solution for use in police custody centres used by NHS staff and commissioned services. It is used as a clinical health recording system to support clinical care delivery for patients in police custody.

110. Senior managers informed us that all staff had completed their induction, and in the evidence provided to the inspection team, we were assured that the majority of staff were compliant with their mandatory and role specific training. Senior managers told us that they intend to carry out a training needs analysis in the near future, to support the continued professional development of staff and to ensure that all staff training remains contemporary.

111. Staff received clinical supervision from the SCN every 4-6 weeks. We saw an example of a supervision record which was comprehensive, covering various aspects of practice and governance. We were informed that the majority of staff had a current Personal Development Plan and appraisal in place.

112. The DATIX (risk management information) system was being used appropriately by healthcare staff to record any incidents and adverse events. Incidents were reviewed and learning shared within team meetings.

113. There was no visible information about how a detainee could make a complaint or give feedback on the healthcare service they received within the centres. We were informed that this information would be provided on request. At the time of our inspection we found no evidence of any complaints being submitted within the past year.

Recommendation 8

NHS Lothian should ensure that information about how to make a complaint is visible and shared with patients.

114. A quarterly health and safety audit was completed. However, there was no formal programme of audit with senior management overview in place to monitor and evidence practice to drive improvement across the custody healthcare service.

Recommendation 9

NHS Lothian should introduce a regular programme of audits to assure themselves and the public of the quality and safety of healthcare delivery.

115. In both centres, clinical examinations were generally carried out in a dedicated treatment room. Although the door to the treatment room could be closed when an examination was being carried out, healthcare staff we spoke with informed us that the door was generally kept open with a member of custody staff outside the room for safety reasons.

Area for improvement 3

The custody centre should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.

116. Treatment rooms in both centres were visibly clean and generally in a good state of repair. Flooring, surfaces and the ceilings were intact ensuring effective cleaning could be carried out, however there was some damage to the walls in both centres. Despite the foregoing, it was noted that the treatment room in Dunfermline was small and cluttered, potentially making effective cleaning difficult. Healthcare staff told us that they were responsible for cleaning the surfaces and clinical wash hand sinks in the treatment rooms, while the cleaning of the floor was the responsibility of an external cleaning company. An appropriate chlorine-based cleaning product was available for cleaning the clinical wash hand sink in line with current guidance. Cleaning of the cells and custody area in both centres, including the management of blood or body fluid spillages, was completed by an external company. Spillage kits[21] were available for body fluid spillages in the treatment rooms. Cleaning staff informed us that they were not provided with a chlorine-based product for cleaning sanitary fittings in the custody area.

Recommendation 10

Police Scotland should ensure that chlorine-based cleaning products are available for cleaning in line with national guidance (NIPCM).[22]

[21] Spillage kits contain all that is needed to clean and decontaminate an area after a blood or body fluid spillage has occurred.
[22] National Infection Prevention and Control Manual.

117. In both centres, care equipment was visibly clean and in good condition. Healthcare staff told us that equipment was cleaned daily and in between patient use. Hand hygiene facilities were available, and we observed healthcare staff carrying out appropriate hand hygiene. Personal Protective Equipment (PPE) was also available.

118. Sharps bins, which are used to dispose of used needles or sharp medical items, were seen to be correctly labelled with their temporary closures in place. Clinical waste bins were available and were not overfilled. Police Scotland hold the waste contract with an external company for the collection of clinical waste and sharps bins. We were told that there was no secure area for storing filled clinical waste bags and sharps bins awaiting collection and at times these had be kept in the treatment room until collected.

Recommendation 11

Police Scotland should identify an area where clinical waste and sharps bins can be stored securely until they are collected.

119. No linen was used by healthcare staff. Linen used in the custody area was managed by custody staff and was laundered by an external company. Used linen was stored securely while awaiting collection.

120. We were told that there was no infection prevention control (IPC) lead for the custody centres in Dunfermline and Kirkcaldy. However, staff could obtain IPC advice from NHS Lothian. We observed that the National Infection Prevention and Control Manual (NIPCM) was available on the staff shared drive. Staff were not aware of any external IPC inspections having taken place to provide assurance.

Recommendation 12

NHS Lothian should ensure that an Infection Prevention and Control lead for custody centres is identified and that external assurance visits are implemented.

121. Senior healthcare staff told us that nursing staff were trained in basic life support and that training was enhanced to reflect the health conditions of patients in custody settings, such as substance use. Custody staff were trained in first aid. Posters were displayed and staff demonstrated knowledge of what indicated an emergency. Systems and processes were in place for the management of emergency situations including the use of emergency ambulances to take detainees to hospital if necessary. Emergency equipment, including oxygen and automated external defibrillators were available in both centres. Emergency equipment was well organised, with evidence of regular checks being completed. Emergency medications were also available.

Access to healthcare

122. As stated previously in this report, patient healthcare needs were identified through a vulnerability questionnaire completed by custody staff when people are brought into custody. The information given by the detainee when completing the vulnerability questionnaire may result in a referral being made to healthcare staff. Referrals received were triaged by nursing staff, and patients were then seen based on their clinical need. The outcome of this triage, such as an estimate of when the patient would be seen, was communicated to the custody sergeant.

123. Detainees could also request to see healthcare staff at any point. Healthcare and custody staff told us that these requests would always be facilitated. Information regarding healthcare was included in the letter of rights that was routinely given to detainees. Healthcare and police custody staff could access interpretation services to support the vulnerability assessment and ongoing healthcare assessments. Language identification posters were visible in the charge bar area of the custody centres.

124. The separate electronic systems used by custody staff and NHS staff to record custody data are unable to connect with each other to share information. Custody staff use the NCS system to record information relevant to detainees, whereas NHS staff use Adastra. Therefore, recommendations made following a patient's assessment were emailed to the custody staff and then copied onto NCS where appropriate.

125. Healthcare assessments were recorded on the Adastra system with assessments documented electronically on a standardised template. We reviewed five patient records on the Adastra system and saw these to be completed well, covering assessment, care planning, risk assessment and harm reduction advice.

126. Staff were aware of the process for identification and documentation of injuries allegedly sustained because of force. Where possible, any detainee request for specific healthcare staff to carry out health assessments would be facilitated. Cells in the custody centre at Dunfermline were wheelchair accessible, however, those at Kirkcaldy were not. Therefore, detainees with any mobility issues could not be managed at Kirkcaldy and would have to be transferred to another custody centre.

Medicines management

127. There were clear processes for managing medicines which healthcare staff used to safely prescribe, administer, record and store medicines. A process was also in place to order medications including controlled drugs.

128. The standard operating procedure '*Management of Medications in Police Custody Healthcare – General Local SOP*' stated that the Registered Nurse or Custody Sergeant should not accept receipt of medication where packages are unsealed or did not match the original order. However, staff informed us that this wasn't standard practice for the Custody Sergeant role. We suggest that NHS Lothian reviews and amends the standard operating procedure to provide clarity.

129. Healthcare staff told us that a pharmacist attends the custody centres to safely destroy out of date or no longer required controlled drugs. We observed that controlled drug registers were completed well and there was evidence of a controlled drug license in place. However, whilst there was evidence of expiry dates of medications being checked, inspectors found out of date medications during inspection. These were immediately removed by the nurse after we highlighted this issue.

130. NHS Lothian has recently appointed a pharmacist with responsibility for overseeing the governance of medicine management in the custody centres in the Southeast cluster which includes Dunfermline and Kirkcaldy. We welcome this appointment and the potential to continue to improve medication management.

Recommendation 13

NHS Lothian must ensure that a robust date checking procedure is in place to identify medicines approaching expiry dates.

131. Various methods were used to ensure robust medication reconciliation, including checking electronic records and speaking with the patient's usual pharmacist. This ensured that patients received their usual medication whilst detained, including any Opiate Substitution Therapy (OST). Most of the healthcare staff were non-medical prescribers and prescribed all medications.

132. Healthcare staff dispense medication into multi-compartment compliance aids[23] to enable custody staff to administer medication, apart from OST which is dispensed by a nurse. The compliance aids were held by custody staff who received email instructions from healthcare staff to support safe medicine administration. The NCS computer system alerted custody staff when medications were to be administered.

133. No formal audits of nurse or FME prescribing were being carried out at the time of inspection, although we were told that this was discussed during individual staff meetings with the SCN. As highlighted, audits should be undertaken to provide assurance of safe quality care.

134. Patients suffering from alcohol or drug withdrawal received appropriate detox medication if required and appropriate tools were used to monitor withdrawals. OST was prescribed so that this treatment continued while the patient was detained. Nicotine replacement therapy was also available.

135. Senior healthcare staff told us that incidents involving medications were actively encouraged to be reported and were reviewed as part of REAS governance process with learning being shared with staff at regional meetings.

[23] Royal Pharmaceutical Society, Multi-compartment compliance aids (MCAs), September 2022.

Substance use

136. The vulnerability questionnaire used by custody staff when detainees arrive at custody poses questions to detainees regarding the use of substances or whether they have substance dependency. CFNs assess detainees who appear to be under the influence of alcohol or substances, or withdrawing from these, and use the appropriate tools for monitoring withdrawals. CFNs also carry out physical observations and prescribe medication where required.

137. There were processes in place for confirming, collecting and administering community prescriptions for patients within custody who were prescribed OST. For patients appearing in court, OST is not routinely given prior to attending. In some circumstances this was in the context of early morning court appearances. Communication systems were in place for OST to be administered to patients upon release through local pharmacy services. However, where court appearances are later in the day there is a risk that some patients can go for extended periods of time without their OST and can miss their prescribed dosage on liberation from custody dependent on the time of release.

Recommendation 14

NHS Lothian must ensure that detainees receive their OST treatment as prescribed when transferring to court or on liberation from custody.

138. The Scottish Government's Medication Assisted Treatment (MAT) standards came into force in April 2022. These are evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. Whilst healthcare staff had an awareness of the MAT standards and had embedded practices in line with standard 4 regarding harm reduction, there had been limited progress in terms of further implementation. However, this was identified within the lead nurse role including future plans to address how MAT can be implemented in custody.

139. Harm reduction interventions were available to detainees with some nurses trained in motivational interviewing, alcohol brief interventions and low intensity psychology interventions. At the time of inspection, there was no blood-borne virus testing, however this was well established in other custody centres where NHS Lothian were the responsible board. Senior managers advised inspectors of imminent plans to replicate this practice within Fife custody. Both treatment rooms had information about take-home Naloxone kits and contact numbers for support organisations, including community addiction services. Take home nasal Naloxone kits were available and there was evidence of these being offered to patients. All healthcare professionals, police custody constables and sergeants were trained and had access to Naloxone. Healthcare staff had access to Naloxone in the treatment room and officers carried nasal Naloxone on their belts. Evidence showed there was a good uptake of harm reduction interventions offered. We considered the harm reduction provision to be good practice.

140. A pathway was in place to refer patients to the community addictions team. Collaborative work was also evident with CFN's liaising with community addictions workers to make initial referrals or to ensure continuity of care for patients.

Mental health

141. Healthcare staff triage and assess patients' mental health within custody using a standardised assessment including the patient's history, details of examination and assessment and recommendations. Our review of patient care records in relation to mental health showed detailed assessments and recording of associated care plans and recommendations. There was evidence of relevant information being shared confidentially with custody staff, where appropriate. A standardised risk assessment tool is available on Adastra for CFNs to identify people at risk of self-harm or suicide. Risk management plans were seen to be reflected within the recommendations shared with custody staff such as enhanced monitoring or observation levels, where there was a concern for a patient's wellbeing.

142. Processes are in place for patients requiring mental health assessments including flowcharts highlighting the different NHS board pathways depending on a patient's circumstances. Staff informed us of occasional delays for mental health assessments, however highlighted their ongoing engagement with NHS Fife to support the timeliness of assessments.

143. Learning disabilities can also be identified from the vulnerability questionnaire and systems were in place to involve an appropriate adult service if required.

144. Patient care records and discussions with staff demonstrated that interventions were carried out with a trauma-informed and person-centred approach. With the patient's consent, CFNs routinely share information with the patient's GP, community psychiatric nurse or relevant community mental health service with concerted efforts to maintain continuity of care.

145. Custody data showed that Fife custody centres were rarely used as a place of safety under section 297 and 298 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (referred to later in this report as the 2003 Act).

Pre-release pathways and referrals

146. When a detainee is moved from a custody centre to another area, for example when going to court, a Person Escort Record (PER) form is completed. This form contains information regarding the detainees' medical conditions and medications. We were told that healthcare staff communicate any relevant health information or concerns to custody staff completing the form, such as medical conditions or medication.

147. A number of posters were visible throughout Dunfermline custody centre signposting detainees to community support services. Kirkcaldy custody centre had less resources displayed, however both centres had weekly visits from Sacro[24] Custody Navigators to offer detainees a range of support in the community. Custody and healthcare staff were knowledgeable about the support available in the community and routinely made referrals or signposted people for mental health, substance use, health and wellbeing, harm reduction, peer support and family support services available in the community.

[24] Sacro is a Scottish community justice organisation providing services designed to help people live safely in their communities with sufficient support to address their individual needs and reduce or eliminate the risk of reoffending.

Detainee transfers

148. GEO-Amey are the national escort provider contracted to transfer detainees from Dunfermline and Kirkcaldy police stations to the appropriate Sheriff Court or to prison as required. Kirkcaldy Sheriff court is co-located in the same building as the police custody centre.

149. Custody staff and supervisors described how recent resourcing challenges for GEOAmey have resulted in some delays in detainees being collected and transported to court. These delays can impact negatively on custody operations and on the detainee.

150. We have identified and raised similar circumstances during our previous joint custody inspections. In addition, we are cognisant of the recent work undertaken by Audit Scotland regarding the 2022-23 audit of the Scottish Prison Service, which provides useful comment on the performance of GEOAmey in respect of contractual obligations. We welcome the findings outlined within the resultant report.[25]

151. Personal escort record forms are provided by the escort provider GEOAmey. They should be completed by custody staff for each detainee being passed to GEO Amey in order to summarise the identified risks. This information is also reiterated in an email sent to GEOAmey. The PER forms were examined at both centres and found to be completed to a good standard.

[25] Audit Scotland, The 2022-23 audit of the Scottish Prison Service, 12 December 2023.

Police Constable-led custody centres

152. Police Constable-led (PC-led) custody centres were introduced following extensive review and trials undertaken as part of a custody transformation process. PC-led custody centres have become an integral part of the overall National Custody Operating Model.

153. The premise of the PC-led model is that suitably trained, experienced and approved Police Constables, who have the proven capability to perform the duties of Custody Officer, assume the lead role for coordinating onsite custody operations under the remote supervision of a custody sergeant. They will therefore provide guidance for custody staff as required and provide authorisation for detention and liberation in line with criminal justice legislation and guidelines.

154. Kirkcaldy and Dunfermline are rarely operated on a PC-led basis, however the sergeants based at these centres often supervise other PC-led centres, notably at Hawick.

155. Sergeants stated that they complete at least one shift each week where they remotely supervise Hawick in addition to their own centre. Part of the sergeant's role is to record the necessity and proportionality of arrest under the Criminal Justice (Scotland) Act 2016 and apply a rationale for that and any subsequent criminal justice decision making. While it was accepted that criminal justice decisions could be made remotely, sergeants had some concern that they are responsible for the health, care and welfare of detainees at another centre, whom they had not met. As such, they rely on the staff at Hawick (or other applicable centre) to recommend decisions.

Local policing

156. Inspectors spoke with local police officers and custody supervisors to discuss issues or challenges which can arise. Inspectors were advised that there can be times when an individual may be arrested for a crime and brought to custody rather than be detained under the Mental Health Act and taken to a place of safety (hospital). There can be several potential reasons for this should it occur. For example, it may be due to a lack of access to appropriate facilities or availability of services more suited to mental health crisis. It was suggested that decisions may be based on the demand this places on local policing and that taking a person to custody means a swifter return to operational duties.

157. While as stated previously in this report, we found that the custody centres were rarely used as a formal place of safety, we consider that Police Scotland should examine the extent to which the practice described may take place.

Recommendation 15

Police Scotland should examine the extent to which local policing may at times use custody as an alternative to identifying an appropriate place of safety, and address any issues identified.

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