HMICS Improving Policing Across Scotland

Healthcare Improvement Scotland

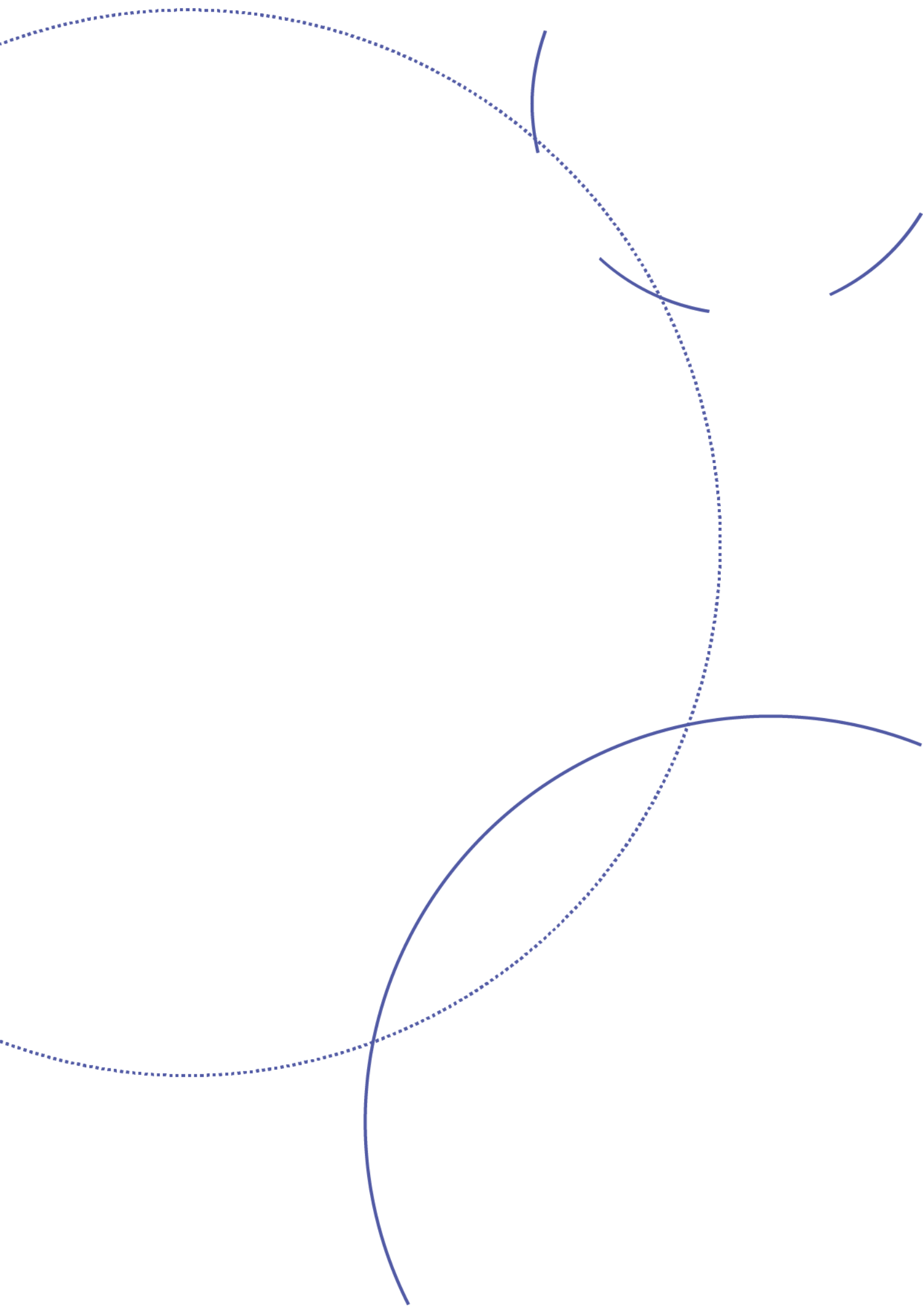
Custody inspection report

Greater Glasgow

March 2025

EFQM

npm national preventive mechanism



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). 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 inspect 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.

Places of detention, including police custody centres within the UK, are monitored as part of the human rights treaty: 'Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and 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.

Joint HMICS/HIS custody inspections focus on the delivery of custody services by Police Scotland and associated healthcare provision by NHS boards and Health and Social Care Partnerships across Scotland. These are underpinned by the joint HIS and HMICS Framework to inspect that ensures a consistent, objective and human rights-based approach to the collaborative work.

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

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.[1] We used learning from the review to develop a framework to inspect healthcare services within police custody, and to devise a methodology for the joint inspection of police custody centres.

On completion of the baseline review, the scrutiny partners agreed to undertake two initial custody inspections to further develop inspection methodology and to complete our inspection framework. We thereafter commenced a programme of joint custody inspections and, to date, have published six custody inspection reports. The findings from these can be found on our website.[2] This report relates to our inspection of primary custody centres in Glasgow, including at London Road, Govan and Cathcart.

The inspection was carried out by HMICS and HIS, the aim of which was to assess the treatment of, and conditions for, individuals detained at the custody centres. This report provides 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 healthcare provider.

While recommendations outlined in this report have specific relevance for Glasgow 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 2, 3 and 4 from this report to have such relevance.

During this inspection, we found common themes that featured as recommendations in our previously published custody inspection reports. We have referenced these within the body of this report where relevant.

[1] HMICS and HIS, National baseline review of healthcare provision within police custody centres in Scotland, 31 January 2023.
[2] Our custody inspection reports are available on our website.

The onsite stage of the inspection took place in September 2024. 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 July 2024. 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 and interviewed custody staff and healthcare professionals during our visit.

This report, similar to recently published inspection reports, highlights our concerns regarding a lack of consistency in the recording of information on the NCS. While some aspects of custody centre operations were recorded well, such as legal rights, the recording of information relating to criminal justice decisions and care plans was found to be lacking. We have continued to find disparities, in some cases, between the risk assessments undertaken and the corresponding care plans put in place to mitigate risk. Similarly, we found a lack of quality assurance of operational practice taking place; an issue which we have raised previously and have made a recommendation for improvement.

We have highlighted the need for increased line management presence within custody centres to ensure the quality and consistency of custody centre operations. In addition, we have outlined the need for increased management oversight of children in custody to ensure they spend as little time as possible in custody and are released as soon as legally permissible.

We found the provision of healthcare within the custody centres to be good, and that it was being delivered within an established and well-managed model.

Police custody has been subject to considerable scrutiny by HMICS since Police Scotland was established. Police Scotland has made progress in implementing previous recommendations and improvement actions in respect of custody services and is actively working to address those that remain outstanding.

We wish to thank the officers and staff of the Criminal Justice Services Division of Police Scotland, as well as those from the Glasgow City Health and Social Care Partnership, which is responsible for healthcare at the centres inspected.

The custody inspection programme is overseen 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 2025

Key findings

- Glasgow has two primary custody centres at Govan and London Road. The additional facility based at Cathcart provides a fallback option for custody services, and although normally closed, was opened during our inspection to allow for remedial work at Govan.

- The facilities at Govan and London Road were considered to be good. However, Cathcart required more urgent and broader maintenance, particularly should it be used more frequently.

- The rear access points at London Road and Govan custody centres comprised of caged vehicle docks with Cathcart being an enclosed vehicle dock. All were secured by fully operational electronic gates, controlled and monitored remotely from the custody office and were located in ‘access restricted’ rear station yards.

- Govan contained a spacious accessible wet room located off the main custody access corridor, however, it was closed due to blocked drainage. Custody staff highlighted that poor drainage also led to frequent flooding of the shower areas, which could make them problematic to use and a potential hazard.

- At Govan, the ‘drink driving’ intoximeter testing equipment was located in a very small room close to the route to and from the charge bar. This could be problematic when the facility has a high throughput of detainees who have consumed alcohol.

- London Road featured a short corridor of cells that had been modified and decorated with the intention of improving the environment for children and young people when they are detained. We were informed that this was no longer used as the default location for children and young people. However, we found no rationale to explain why this facility was not being used as initially intended.

- London Road contained a separate ‘discrete charge bar’, which was reserved for processing ‘sensitive’ arrests, children or other vulnerable detainees. This spacious and well-appointed room also incorporated a video information screen where an informative and age-appropriate, ten-minute video can be presented to vulnerable or young detainees describing the custody facility and clarifying detainee rights and expectations.

- In Govan and Cathcart, inspectors found that some internal doors were not properly secured, which could allow unauthorised egress from the custody areas to the wider station footprints and exits. This was highlighted to custody staff at the time of our visit.

- While each centre had ligature cutters, custody staff at Govan were unable to immediately locate them when requested. These were subsequently located at the charge bar in an unmarked miscellaneous storage box, but only after a few minutes of searching. Cutters were not routinely carried by staff.

- At Govan, we saw four used unsecured and unlabelled sharps boxes lying on the floor of the charge bar, which presented a potential risk to staff.

- In each centre, the separated corridors enabled gender or age-based segregation, and these were routinely utilised for detainees.

- No recent physical evacuation fire drills had taken place in either centre.

- Detainees were offered a referral to a third sector agency for support in several instances, however, this could have been used more consistently as it was not offered to some detainees where it appeared appropriate.

- Interviews with custody staff across the centres suggested that use of Cathcart should be prioritised over London Road on the basis that it would provide increased capacity and would reduce the number of detainees transferred for capacity reasons.

- Visibility of custody managers was described as ‘mixed’ by custody staff, with several senior officers working from home, some on compressed hours. This can impact on effective management oversight of operational processes, staff supervision, and compliance checking.

- Staff at all three custody centres universally cited staff shortages as their primary concern. They advised that they regularly operated under the operational base levels (OBL) for custody centres and described the situation as very challenging.

- We found detainee property arrangements to be well-managed and in good order.

- We observed nine detainees being booked into custody across all three custody centres. At Govan, we saw two charge bars operating simultaneously, though staff suggested that frequent delays were the result of routinely operating only one charge bar at any given time.

- All the detainees we saw were subject to a standard search, which were conducted by CJPCSO’s in a safe, methodical, and respectful manner. We noted that the CJPCSOs at Cathcart and London Road wore personal protective vests to conduct searches.

- Of the 90 records we examined during our review of the NCS, 32 detainees were strip searched, the majority of which were undertaken appropriately. At times, a strip search can be authorised on the basis of a historical drug possession record. We consider that a clear rationale should be recorded in such circumstances to ensure proportionality.

- All detainees were provided with information on their right to a solicitor and reasonably named person, and staff ensured that these were fully explained.

- Within our broader sample, we examined four records relating to children aged between 13 and 15 years. None were held for court but remained in police custody for between six and twelve hours. Each were charged with minor offences. The NCS had no information indicating that an inspector was aware of, nor had sanctioned, these detentions. We consider holding children in a cell for this length of time to be disproportionate with the alleged offence, inconsistent with existing policy, and potentially detrimental to the child.

- We noted in six cases, that there was a delay in the detainee being released following a disposal decision being made. In one instance, this was for an additional nine hours, and in another, for fifteen hours. Neither case featured an appropriate rationale recorded on NCS to explain these delays.

- We found that a record of a formal handover between custody teams appeared in the majority of records reviewed on the NCS. There were 12 records which we considered should have featured a formal handover but did not.

- There was a disparity between some risk assessments and the corresponding care plan and observation level put in place. While risk was mitigated by the use of enhanced CCTV observations, the recording of risk and care plans was inconsistent.

- We noted significant delays between the recorded time of a cell visit taking place and the time that it was entered onto the NCS. While some of these were recorded in good time, in some cases, the delay was lengthy with the longest of these being 86 minutes. This type of delay can result in important information not being available to all staff when required.

- There was limited quality assurance and audit of key processes taking place at the custody centres. While Cluster Inspectors sampled cases for audit, these were often in very small numbers and therefore not reflective of overall practice at the centres. The criminal justice services division are in the process of introducing a new approach to address this concern.

- We interviewed eight detainees across the centres during our inspection. All provided complimentary feedback about their treatment by custody staff and the arresting officers.

- Medication was required in 24 of the records we inspected. For the most part, the NCS was updated appropriately in this respect.

- The Glasgow City Health and Social Care Partnership (HSCP) hosts police custody healthcare on behalf of NHS Greater Glasgow and Clyde. The HSCP is responsible for the delivery of healthcare in this area, which includes London Road, Govan, and Cathcart. The service is nurse led with support from forensic medical examiners (FMEs).

- The police custody healthcare team consists of a peripatetic nursing and medical service. Custody nursing staff were available 24/7, and are on duty over a 24 hour period. The nursing team had a combination of Adult Health Nurses and Registered Mental Health Nurses.

- Overall, healthcare was well managed. The HSCP provided a clear management structure, with monitoring and oversight undertaken through its clinical and care governance processes. Healthcare staff we spoke with described the management team as visible and supportive.

- There was information displayed in all custody centres about how detainees could make a complaint or give feedback. Treatment rooms in all centres were visibly clean and in a good state of repair, with hand wash basins and personal protective equipment available for use.

- Custody staff reported that there was a lack of clarity on whether or not nursing staff would routinely attend for a detainee arrested with a 'not officially accused'[3] status, within the first six hours of their detention. They highlighted that there could, at times, be gaps in these detainees being seen.

- There was an identified infection prevention and control (IPC) lead for all the custody centres and a programme was in place to complete monthly IPC audits.

- At the time of the inspection, it was noted at London Road that the dates on the oxygen mask within the emergency bag and the defibrillator pads had expired.

[3] A person can be arrested 'not officially accused' when there is insufficient evidence to charge them at that time. Their arrest is to facilitate an investigation, take statements, gather evidence, and interview the individual. The period a detainee can be held as not officially accused is limited to 6 hours, however, if at a 6 hour review more time is required to conclude an investigation, a custody review inspector (CRI) can authorise further extensions up to a maximum of 24 hours.

- There was evidence of a Child and Adolescent Mental Health Service (CAMHS) pathway in place for referring children to specialist services if required.

- All medicines, including controlled drugs, were stored securely in locked cabinets and a locked medicine fridge in the treatment rooms. The keys for the medicine cabinets and fridge were kept in a key safe that only healthcare staff could access.

- Processes were in place for medications to be administered by custody staff from compliance aids, apart from Opiate Substitution Therapy (OST), which was administered by healthcare staff. The compliance aids in all custody centres were held securely by custody staff in a locked safe until they were required.

- Processes were in place for confirming, collecting and administering community prescriptions for patients within custody who were prescribed OST. For patients appearing in court, OST was not routinely given prior to attending.

- Data recorded showed a range of harm reduction information and interventions were available to detainees at the custody centres with good uptake. BBV[4] testing was available to detainees accessing healthcare in custody. All healthcare professionals had access to Naloxone[5] and were trained to administer it.

- Training opportunities were available to ensure health staff competencies including access to mental health first aid, skills training in self-harm, suicide prevention and intervention.

- All custody centres had access to a community support service – Positive Outcomes Project (POP), which was viewed very positively by custody and healthcare staff. Peer support workers visited the centres to promote detainee engagement with community support services.

[4] A blood borne virus (BBV) is an infection that can be transmitted from one person (the donor) to another through direct contact of bodily fluids, especially blood.
[5] 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.

Recommendations

Recommendation 1

Police Scotland should examine the staffing levels at the custody centres in Glasgow and make arrangements to ensure that appropriate staff resource is in place to maintain safe and effective custody centre operations.

Recommendation 2

Police Scotland should ensure that an appropriate level of management presence is maintained at custody centres in order to improve the quality and consistency of operational practice and to ensure compliance with approved protocols and standards.

Recommendation 3

Police Scotland should ensure that custody decisions regarding children detained in custody are subject to robust management oversight and are recorded appropriately.

Recommendation 4

Police Scotland should ensure that ligature cutters are stored in a prominent place that is known to all custody staff and that can be accessed swiftly.

Recommendation 5

Glasgow City HSCP should ensure that expiry dates on all equipment at the custody centres are checked to ensure that equipment is within date and ready for use.

Recommendation 6

Glasgow City HSCP should provide custody and healthcare staff with clarity on its position and practice expectations regarding the assessment of detainees with not officially accused status.

Areas for improvement

Areas for improvement	Number
The custody centre at Govan should explore options to relocate the intoximeter to ensure appropriate functioning.	1
The custody centre at Govan should ensure that improvements are made to the management of sharps bins at the custody charge bar.	2

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 a Deputy Chief Constable. Custody is delivered in accordance with the custody standard operating procedure,[6] which is updated and amended regularly to reflect changes in practice guidelines and expectations.

2. National custody throughput has seen an increase over the past three years as indicated in the table below. Greater Glasgow primary custody centres have seen a small reduction in throughput over the past two fiscal years. However, the ancillary centre at Cathcart has been used more frequently in the past year, which brings overall throughput to a similar figure for each of the past two years.

Table 1 – National custody throughput[7]

Year	2019-20	2020-21	2021-22	2022-23	2023-24
Throughput	90311	87408	84010	96279	99986

Table 2 – Custody centre cell capacity and throughput

Custody centre	Number of cells	2022-23	2023-24
Govan	50	8652	8412
London Road	37	7507	7112
Cathcart (ancillary)	58	2265	2973
Total	145	18424	18497

[6] Police Scotland, Care and Welfare of Persons in Police Custody, Standard Operating Procedure, 06 June 2024.
[7] Annual throughput data differs from that previously reported. This is because Police Scotland have adopted new audit software and data recording rules.

3. Custody centres in Scotland are organised into clusters, each led by a Cluster Inspector and Glasgow has two custody clusters, each with one primary custody centre. The custody centres we visited during this inspection were London Road, Govan, and Cathcart in Glasgow. Cathcart custody centre is an ancillary centre. It is normally closed and is used as a business continuity fallback option. It sits within the same cluster as Govan whereas London Road custody centre sits within its own cluster.

4. During our inspection, Cathcart was opened to allow for essential maintenance at Govan custody centre. We inspected Cathcart and we were also able to inspect Govan custody centre when business returned there from Cathcart. We have placed greater emphasis on the two primary centres in this report, however we comment on the facility at Cathcart where relevant.

5. The custody centres serve the Sheriffdom of Glasgow and are located within local area police stations. Because of their size, Govan and London Road also accommodate detainees from neighbouring jurisdictions when necessary.

6. During our inspection, we found that there was considerable discussion amongst custody staff about which centres should be used in Glasgow. We found a commonly held view that Cathcart custody centre should be prioritised over London Road custody centre. It was considered that this would provide the required increased capacity, thus reducing the number of detainees who are transferred for capacity reasons most weekends.

7. Some staff indicated that there is a case for all three centres to be open, particularly at weekends, however it was recognised that staffing challenges may preclude this. The issue of which centres should have primary status appears to reside within a wider custody estate context, with challenges at Greenock, Coatbridge and Motherwell custody centres impacting on the greater Glasgow custody provision, something the area commander referred to as a significant issue.

8. At the time of our inspection, all staff observed the CJSD 222b[8] shift pattern. Each staff team at Govan and London Road custody centre was made up of two police sergeants, a criminal justice police custody and security officer (CJPCSO) team leader, and ten CJPCSO staff.

Independent custody visitors

9. Under the Police and Fire Reform (Scotland) Act 2012, 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 co ordinates 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.

10. 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 significant issues raised.

[8] The CJSD 222b pattern relates to custody staff working two early shifts, two late shifts and two nights, followed by four non-working days.

Methodology

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

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

13. During the inspection, we examined the treatment of, and conditions for, detainees at the centres. 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.

14. A proportional sample of custody records were examined from those created across all custody centres in the Glasgow police division during July 2024. Of the 1,780 records created during that period, 880 related to people processed at London Road and 900 related to Govan custody centre. We sampled 90 records for review on NCS, which equated to five per cent of throughput in that month.

15. 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.

16. 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

17. The custody centres at London Road, Govan, and Cathcart are of late 20th Century construction and have functioned as custody centres under the former Strathclyde Police, and thereafter since the establishment of Police Scotland. Each centre was incorporated into the footprint of existing operational police stations and consisted of single-story layouts with London Road having a capacity of 37, Govan 48, and Cathcart 56 operational cells. Govan also accommodates a separate Home Office specialist detention facility, however, this area was not included as part of this inspection.

18. We examined the route into each custody centre and found the security provision, and operational practicality of each, to be of a very high standard. Each centre was accessed via a secure rear parking yard leading directly from the adjacent public roads, which served as parking for operational police vehicles for both the custody centres and adjoining police stations. These large enclosures were bounded by high walls and featured fully functional steel gates, which were capable of being monitored and remotely controlled from the custody centres.

19. There were multiple, clearly displayed ‘police only’ and ‘authorised vehicles only’ signs affixed to the yard entrance points restricting unauthorised access to the area.

20. The access points at London Road and Govan comprised of caged vehicle docks with Cathcart being an enclosed walled vehicle dock. All were secured by fully operational electronic gates, again controlled and monitored remotely from the custody offices. The respective custody docks could accommodate multiple smaller vehicles as well as larger 14 cell custody transports.

21. These rear yards and custody docks were very well covered by CCTV cameras, viewable from the custody office and all three were clean and free of unnecessary or hazardous items. The yards, vehicle docks, electronic gates, and the security features around these, were the best that we have seen since the commencement of our joint custody inspection programme.

22. At each facility, detainees enter the custody suite through accessible, keypad secured doors, after which they are led through secure access corridors to the holding rooms and processing areas. In each of the facilities, the corridors incorporate dedicated rooms for conducting discrete searches or, where necessary, decontamination of detainees. In the case of Cathcart this also included wet-room washing facilities.

23. The access corridors also housed other elements of custody infrastructure such as storage rooms and rooms to house livescan impression machines and 'drink drive' testing intoximeters.

24. At Govan, the intoximeter machine was located in a room, which owing to its small size and location close to the route to and from the charge bar, could be problematic when the facility has a high throughput of detainees who have consumed alcohol.

Area for improvement 1

The custody centre at Govan should explore options to relocate the intoximeter to ensure appropriate functioning.

25. Adjacent to the processing areas in each centre were spacious holding rooms. Two each in the case of London Road and Govan and one larger room at Cathcart. Each single benched room was directly overlooked by the charge bars and were covered by CCTV cameras. Only London Road featured affray activation panels.[9] All holding rooms contained multiple information posters conveying details regarding CCTV recording, disability awareness, detainee rights, support services, staff procedural prompts, complaints process and translation facilities. We consider this to be good practice.

[9] Affray panels are fitted throughout custody centres (and other facilities) and are used to trigger an alarm, which will initiate a response from other officers to assist at the location where the alarm is activated.

26. All centres featured spacious processing areas containing three charge bars in differing configurations. All charge bars were at custody floor level separated from the custody side by retro-fitted, half-length Perspex safety screens. The charge bars, which contained single seated processing stations, were separated from the next by very shallow, full-height partitions. However, due to the shallow nature of these, they offered little in the way of discrete separation of the processing spaces and in the case of Govan's open plan design, reportedly led to disruptive noise levels.

27. Conversely, London Road contained three bright, spacious and practical charge bars, each separated from the other by full-height walls. There was also an additional separate room that contained a discrete charge bar where selected detainees such as children and young people or vulnerable individuals could be processed. This bright and accommodating space also included a video information screen where an informative, and age-appropriate, ten-minute video provided an animated description of the custody process including confirmation of detainee rights, support facilities, and what detainees should expect to encounter during their detention. This innovative presentation video was viewed by inspectors and found to be a very positive and constructive approach to assist in reducing anxiety and conveying detainee rights. We consider this to be good practice.

28. Detainee property storage at the centres was located in CCTV monitored rooms immediately adjacent to the charge bars and was provided by way of lockable floor mounted steel lockers. All processing areas, where detainee property is handled, were covered by multiple CCTV cameras, including overhead microphones. We found detainee property arrangements in the centres to be secure and well managed.

29. The charge bars in each centre were situated adjacent to custody staff offices and these spaces afforded convenient access to the wider custody centre via connecting corridors. These areas housed additional facilities such as detainee engagement and interview rooms, well-appointed medical examination rooms, staff only rest areas, multiple storerooms for various materials, photograph/impressions rooms, dedicated staff and detainee kitchens, and forensic storage.

30. At Govan, the centre contained a spacious and accessible wet room, located off the main custody access corridor. However, the facility was closed at the time of our inspection due to the presence of an unpleasant odour attributed to blocked drainage. This was described by staff as an ongoing problem. Similarly, staff advised that poor drainage systems also led to frequent flooding in the shower areas, which rendered them difficult to use and potentially hazardous.

31. As outlined in our report on the joint inspection of primary custody centres in Argyll and West Dunbartonshire, we have made recommendations that have relevance across the custody estate. **Recommendation 1**, of that report states that:

"Police Scotland should ensure that the maintenance and repair of crucial custody infrastructure is addressed swiftly to maintain operational capability as well as safety and security standards."[10]

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

32. At both Govan and Cathcart, inspectors found security issues that require to be addressed. In Govan, a door leading from the processing area to the identification parade room was found to be insecure. This facility, which was being used as a general store for various police equipment, including public order shields, led directly to the station footprint and insecure egress points.

33. Additionally, the access door leading from the detainee side of the Govan charge bar to the staff office, despite having a keypad locking system, was kept open for ease of movement and had no signage prohibiting unauthorised entry. The staff office itself, though routinely occupied, had a further insecure door leading to the wider station footprint and egress points.

[10] HMICS, Custody Inspection Report – Argyll and West Dunbartonshire, Recommendation 1, 24 October 2024.

34. At Cathcart, a secondary access point leading from the staff side of the charge bar to the wider station footprint was secured by a potentially lockable door, however this was unlocked at time of inspection affording potential egress from the custody centre. The only impediment to this movement being a low-level saloon style door. These issues were highlighted to staff during our inspection, however we anticipate that these issues will be addressed in accordance with security standards and expectations.

35. As outlined in our report on the joint inspection of primary custody centres in Argyll and West Dunbartonshire, we highlighted in **Area for Improvement 1**, that:

"The custody centres should review internal and external security features and take appropriate steps to mitigate risks and ensure outstanding repairs are made."

While this has relevance for Govan and Cathcart, we do not intend to make an additional area for improvement in this regard.

36. All custody centres had two well-appointed kitchens designated for exclusive staff or detainee purposes. The kitchens were spacious, tidy, hygienic, and contained a variety of appropriate foodstuffs. Food hygiene, safety and preparation guidance was in place.

37. The custody centres had clear, suitably located, multilingual posters within the charge bars to assist in identifying language translation requirements. The centres also had clearly visible literature and posters to guide staff on expectations regarding movement and handling, security and welfare provision, and general risk considerations for incoming detainees, as well as materials publicising detainee rights and support services.

38. At London Road and Govan, the staff offices were bright, spacious and contained nine and six workspaces respectively, including a station assistant's desk. Cathcart's two staff offices were smaller and separated but nonetheless well-appointed, containing six workstations. Whiteboards were clearly visible and used for relevant detainee care and welfare notes. Suitable staff rest and refreshment spaces were provided within the wider station footprints.

39. All staff offices featured wall mounted CCTV screens providing images from custody cells, which were prominent, adjustable, and positioned so as to afford clear and discrete views of selected CCTV feeds.

40. All centres had dedicated in-cell CCTV observation facilities located on the custody footprint. Govan had six viewing stations located in two separate rooms located in the cell corridors. Cathcart had two observation stations located off the main office containing double monitors. London Road contained a single room with six observation stations located off the main staff office, however, this space was open to the main office, which could result in distraction during busier periods. All rooms were suitably lit, ventilated and equipped with fans. Viewing stations were separated by partitions and there were multiple posters providing guidance for observers on potential risks and hazards associated with people in custody.

41. There was sufficient, clearly visible and practically located fire safety signage, emergency lighting, and materials located throughout each custody centre. This included fire safety warden specific guidance in a clearly marked location. There were stores of rigid and soft wrap handcuffs for evacuation of detainees in the charge bar areas of the facilities, however, these items were not numbered.

42. While routine weekly fire alarm tests were being carried out in all three centres, there was no fire evacuation plan affixed to the wall in the custody office at Govan. This was highlighted by inspectors and rectified on the day. However, no recent physical evacuation fire drills had taken place at the centres.

43. 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 2** from that report states that:

    "Police Scotland should ensure that a full evacuation of custody centres is undertaken in accordance with fire safety regulations."[11]

    While this has relevance for London Road, Govan and Cathcart custody centres, we do not intend to make an additional recommendation in this regard.

[11] HMICS, Custody Inspection Report – Lanarkshire, Recommendation 2, 20 April 2023.

44. At Govan, detainee interview rooms were covered by the custody CCTV system and had affray panel links, however, there were no affray panels in the corridor itself, which was otherwise concealed from general view by the solid panel secure access door. This arrangement may present a risk in the event a detainee becomes unruly in this space.

45. In each centre, the separated corridors enabled gender or age-based segregation. This approach was routinely employed for detainees, which we consider to be good practice and an appropriate use of the bespoke layout.

46. All three centres had access to secure, monitored exercise spaces, each linked to the corresponding male and female cell blocks and vehicle docks. All were considered to be good options affording appropriate and secure access to fresh air and exercise for detainees, particularly for those experiencing difficulties with confinement or those detained for extended periods. However, we were advised that these were not used for this purpose.

47. Overall, the three centres were adequately provisioned with well situated and fully functional CCTV cameras linked to the charge bar and staff offices. Staff were not issued with personal alarms, however, apart from the Govan interview corridor, the majority of wall surfaces and adjacent rooms were fitted with multiple affray panels, the activation of which will activate a loud siren and blue flashing light audible throughout the centres. These panels were easily accessible, highly visible, and linked to a central control panel located in the custody offices.

48. The general condition of the custody centres, notwithstanding the aforementioned issues, was good. There was evidence of minor damage to some parts of the building fabric at Cathcart, which required more urgent maintenance, particularly should it be used more frequently. However, these instances had been identified and documented by staff for appropriate remedial action.

Condition of cells

49. The cells complex at London Road comprises 37 operational cells, distributed as 21 and 16 in each parallel corridor. Six cells were designated for children and young people and while conventional in structure, they featured a range of youth-oriented colour schemes and designs intended to be calming and reassuring for occupants. The designs incorporated advice and supportive messaging in the form of speech bubbles on walls and ceilings of both the cells and external corridors. These cells, one of which was temporarily being used as a store, were also capable of segregation from the wider population by closure of a connecting door.

50. Thirty-one cells were inspected during this visit with five being occupied and one cell being closed pending essential repairs. The remainder were found to be in generally good physical condition with no ligature hazards and only two intermittent buzzer faults found and reported to staff.

51. The cells complex at Govan comprises 48 operational cells with two cells re-purposed as stores. The cells were distributed across five corridors. Forty-five cells were inspected during this visit with two being occupied and one closed pending essential repairs. The remainder were found to be in generally good physical condition with no ligature hazards and only minor cosmetic paint issues.

52. The cells complex at Cathcart comprises 56 operational cells with two cells re-purposed as stores. The cells were distributed in five cell blocks with one block of eight cells, three blocks of twelve, and one of fourteen.

53. Forty-nine cells were inspected during this visit with four being occupied and three closed pending essential repairs. Twelve cells had significant cracking in the paintwork along an apparently similar line of weakness, which ran through the structure of the connected walls. The damage was mostly cosmetic and resulted in thin coats of paint flaking.

54. The cells in all centres contained toilets with external, and in the case of London Road, internal controlled flush, with paper supplied on demand. Detainees in each centre had access to numerous, well-distributed showers and washbasins supplied with hot and cold water. Each facility had an accessible shower facility and there were ample washing materials and feminine hygiene products available at each facility. London Road had the additional amenity of automated hand washing and drying units integrated into the cell walls, which were 'anti-ligature' by design.

55. Cells in all three centres contained low plinths able to accommodate the thick mattresses and separate pillows supplied. Cells were illuminated by dual mode artificial lighting and natural light from glass brick windows/skylights.

56. The cells at both London Road and Govan contained internal, two-way intercom call buttons linked to the charge bar and staff office. All intercoms were tested and were fully operational. In Cathcart, the cells had 'call only' buttons linked to the charge bar and staff office. All available call buttons were tested and found to be functional, however, multiple buttons had inoperative activation confirmation lights. With no intercom facility or audible confirmation of buzzer activation, this meant occupants in these cells would be unsure if their call was acknowledged until staff attended at the cell. All faults were reported to the custody sergeant and noted for further action.

57. All cell doors were of contemporary construction, with three position service hatches, vertical peep grille and slam locks. All cells had functional CCTV cameras, microphones and smoke detectors linked to a VESDA VLS panel,[12] suitably located for custody staff oversight. There were no dry cells, however, covers were available for cell toilets when required. There were sufficient anti-ligature blankets, which were clean and subject to weekly laundering.

58. Cell checks, in the fully operational facilities, were being conducted each week by custody staff. These include a check of the AED equipment. Issues are recorded electronically and manually on the white board and addressed under the direction of the custody supervisor. All inspected cells were generally clean, tidy and subject of a regularly scheduled cleaning regime.

[12] 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.

59. Cleaning is provided by external contractors whose cleaners attend each morning, seven days per week. If, however, cells are not vacated in time for cleaners and capacity is required, custody staff stated that they will undertake the cleaning duties, despite not having received any formal training in the appropriate use of cleaning chemicals.

60. As outlined in our report on the joint inspection of primary custody centres in Dumfries and Galloway, we have made recommendations that have relevance across the custody estate. **Recommendation 5** from that report states that:

"Police Scotland should ensure that custody staff receive appropriate training and guidance where cleaning is part of their role."[13]

While this has relevance for London Road, Govan and Cathcart custody centres, we do not intend to make an additional recommendation in this regard.

Custody centre staffing

61. Custody sergeants are responsible for all criminal justice decisions and their function is specified in legislation. CJPCSO Team Leaders (team leaders), line manage custody staff and are responsible for the care and welfare of detainees, but only once a sergeant has approved the initial care plan.

62. Sergeants stated they are supportive of the team leader role as they are able to spread the responsibility for supervisory duties, albeit they intimated that team leaders were rarely relocated to provide cover if required at other centres. Each team has two sergeants however, when both are available for duty, one sergeant is often moved to supervise another centre as a peripatetic resource.

63. We found that team leaders viewed themselves and sergeants as peers and had equal responsibilities, whereas sergeants generally expressed the view that they had overall command of a custody centre. Established CJSD policy states that supervisory roles are a shared 'collegiate' responsibility, which was the view expressed by the custody area commander.

[13] HMICS, Custody Inspection Report – Dumfries and Galloway, Recommendation 5, 8 November 2023.

64. We highlighted the importance of ensuring clarity regarding the role of custody supervisors in our custody inspection report on Tayside, particularly in respect of which of the custody supervisors is ultimately in charge should an adverse incident occur. We made the following **Recommendation 2**, which states:

"Police Scotland should ensure 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."[14]

While this has relevance for Glasgow custody centres, we do not intend to make an additional recommendation in this regard. However, we will continue to explore this issue during the course of forthcoming custody inspections.

65. Govan and London Road custody centres have a large capacity, which is business critical for the custody division, providing much needed capacity for Greater Glasgow and neighbouring clusters when demand is high. As such, the Glasgow centres are not operated as Police Constable-led centres which would significantly restrict capacity.

66. Custody staff at all three centres universally cited staff shortages as their primary concern. They stated that they frequently operate under the operational base levels (OBL) for custody staffing. The situation was described as very challenging, with some staff saying that they were unable to complete all of the required tasks. When a team leader is absent, they are not usually backfilled and, in their absence, sergeants work alone, absorbing the responsibility of the team leader in addition to their own criminal justice responsibilities.

67. Staff highlighted that it was not unusual for a single sergeant to supervise a custody centre alone. At busy times, that individual could be responsible for the care and wellbeing of 40 detainees, in addition to the criminal justice decision making for new business, reviews and disposals. Sergeants described such circumstances as being very challenging and stated they consider it almost impossible to keep abreast of all matters which demand their attention and consideration at such times.

[14] HMICS, Custody Inspection Report – Tayside, Recommendation 2, 20 July 2023.

68. Staff shortages within custody were also raised by local policing officers during our interviews with them. They highlighted that staffing challenges within the custody centres can lead to an increase in their requirement to backfill for constant observation duties.

69. Custody staff described high levels of overtime working, and what they considered to be high sickness absence levels, which alongside some staff being on long-term restricted duties, reduced the overall staff resource at the centres. These factors can place increased pressure on staffing and may compound workplace stress and frustration, which in turn can invite further absence.

Recommendation 1

Police Scotland should examine the staffing levels at the custody centres in Glasgow and make arrangements to ensure that appropriate staff resource is in place to maintain safe and effective custody centre operations.

70. During our inspection, staff indicated that the visibility of middle/senior management within the custody centres was ‘mixed’. It was found that some Cluster Inspectors visited frequently but others were notably absent from the custody centres.

71. It was reported that several senior officers work from home and some worked compressed hours, which staff felt contributed to the low levels of management visibility. The presence of line managers and senior managers in custody settings has the potential to ensure services are delivered effectively and that organisational culture, values and standards are modelled and maintained. This issue should be explored further by the custody division to identify where improvements can be made.

Recommendation 2

Police Scotland should ensure that an appropriate level of management presence is maintained at custody centres in order to improve the quality and consistency of operational practice and to ensure compliance with approved protocols and standards.

Arrival at custody and booking-in process

72. A custody coordinator role was introduced for custody centres in the Greater Glasgow area in order to address a recommendation made by HMICS in a report on the Inspection of Custody Centres in Greater Glasgow Division. **Recommendation 1**, stated:

"Police Scotland should reconsider how it can better manage custody queue levels and provide radios to large custody centres to improve communication inside the centre and with local policing."[15]

73. The custody coordinator operates from London Road custody centre between 16:00 and 02:00 hours, seven days a week, monitoring a dedicated radio channel. When an officer arrests a person during the specified hours, they contact the coordinator by radio, who notes brief details and directs them to the most suitable custody centre. Decisions are based on location of arrest and likely queueing times across centres with the intention of providing local policing officers with an efficient and effective custody service.

74. We spent some time with the custody coordinator at London Road and observed the positive interactions with local policing officers and custody centres regarding the effective accommodation of detainees. To inform the decision-making process, custody staff made appropriate checks on various police IT systems, notably CHS, PNC, the national custody system and iVPD,[16] to better understand detainee particulars prior to their arrival.

75. The coordinator role was universally welcomed by staff, with many believing it should operate full time rather than only in the evening. We consider the process to be a positive introduction, which had become well-embedded and beneficial.

[15] HMICS, Inspection of custody centres in Greater Glasgow Division, Recommendation 1, 12 June 2019.
[16] Police information systems include the Police National Computer system (PNC), Criminal History System (CHS), and interim Vulnerable Persons Database (iVPD).

76. Subsequent to the creation of Police Scotland in 2013, a section of London Road custody centre was adapted to be more suitable for children and young people. The development was initially part-funded by a third sector agency contribution on the basis that the centre could be used as a default destination for young detainees. Local policing officers were initially encouraged to use the facility in the event they had cause to arrest a child. However, it was apparent from interviews with local policing officers that the centre was no longer used as a default destination for children. Custody staff also stated that police officers were encouraged to attend the nearest custody centre when they had a child in custody. We found no rationale to explain why this facility was not being used as initially intended.

77. Custody staff highlighted that the CJSD aimed to minimise the number of child arrests wherever possible, and to reduce the time spent in custody at the centres. The division also aimed to reduce the time spent conveying children to custody centres.

78. However, our review of records highlighted anomalies in the length of time some children spent in custody. As indicated, we examined records relating to children under 16 years of age. None of those in our sample were held for court, however we noted that a 13 year old was held in custody for over six hours. Three children aged 14 years, were held in police custody for over six, ten and twelve hours respectively. In addition, a 16 year old, that was the subject of a supervision order, was held overnight for more than nine hours. Each was charged with what we consider minor offences and NCS contained no record to indicate that a custody inspector was aware of, nor had sanctioned, detention decisions.

79. We consider holding children in a cell for this length of time to be inappropriate, disproportionate to the offence, inconsistent with custody policy, and potentially detrimental to the child. None of these records contained a sufficient rationale to explain why it was necessary and proportionate to delay liberating the child.

Recommendation 3

Police Scotland should ensure that custody decisions regarding children detained in custody are subject to robust management oversight and are recorded appropriately.

80. Despite the centres featuring three charge bars, local policing supervisors and officers commented that none of the centres routinely operated more than one charge bar at a time, meaning that available capacity was not being used to its full potential. Whilst we witnessed two charge bars operating simultaneously at Govan, we have identified similar issues during our previous joint custody inspections.

81. We observed nine detainees being booked into custody across all three custody centres. The general standard of booking-in processes was good.

82. When an arrested person is brought to a police station they should always be searched. Often this search is limited to clothing and pockets, known as a standard search, but there are occasions where it is appropriate that the search involves the removal of the detainees clothing. Strip searches should be conducted in a dignified manner and must be authorised by a sergeant based on risk, necessity, and proportionality.

83. All of the detainees we saw were subject to a standard search and these were conducted by CJPCSOs in a safe, methodical, and respectful manner. We noted that the CJPCSOs at Cathcart all wore stab vests and at London Road staff donned a stab vest to conduct the search, however, staff at Govan were not wearing these. All three centres have dedicated rooms with no CCTV utilised for strip searches. This provision is uncommon and we consider it to be good practice.

84. During the search, the detainee's personal property was placed onto the charge bar in front of them and in scope of the CCTV. Property items were logged onto the NCS, placed into a sealed bag and stored within an individual locker pertaining to the cell number. In contrast with comments made regarding this issue in our previous custody inspection reports, detainee property was managed well at the centres in Glasgow.

85. Of the 90 records examined, 32 detainees were subject to a strip search, the majority of which were undertaken appropriately. At times, a strip search can be authorised on the basis of a historical drug possession record. We consider that if it is necessary and proportionate for a detainee to undergo a strip search, there should be a suitable rationale recorded that provides clear grounds, and each instance should be authorised appropriately. None of the detainees reviewed in our sample had been the subject of an intimate search. We understand that such searches are very rare and, when undertaken, are conducted on medical grounds and by a medical professional.

86. The issue of maintaining accurate records on the NCS, and specifically in respect of recording relevant information relating to strip searches, was addressed in a recent inspection report. **Recommendation 3** from our joint inspection of the Tayside custody centre states:

"Police Scotland should ensure that the recording of strip searches at Dundee custody centre provides an accurate reflection of practice."

This issue has clear relevance for the custody centres in Glasgow. However, while we anticipate this issue will be addressed, we do not intend to make an additional recommendation in this regard. We will continue to monitor this issue closely on future custody inspections.

87. Whilst each centre had ligature cutters, staff at the Govan custody centre were unable to immediately locate them when requested. These were subsequently located at the charge bar in an unmarked miscellaneous storage box, but only after a few minutes of searching. Cutters were not routinely carried by staff.

Recommendation 4

Police Scotland should ensure that ligature cutters are stored in a prominent place that is known to all custody staff and that can be accessed swiftly.

88. At Govan, we saw four open and used sharps boxes lying on the floor behind the charge bar. These presented a trip hazard but were also unlabelled, closed nor sealed, which presents a health risk. We found that staff were unaware of procedures relating to the management of sharp waste containers.

Area for improvement 2

The custody centre at Govan should ensure that improvements are made to the management of sharps bins at the custody charge bar.

Legal rights

89. All detainees were provided with information on their rights to a solicitor and reasonably named person, and staff ensured that these were fully explained. We noted that a letter of rights was provided to each detainee at Govan and Cathcart, however this did not happen routinely at London Road, despite there being ample supplies on the desk.

90. The Police Interview – Rights of Suspects (PIRoS) form is only completed when a detainee is to be interviewed as a suspect. Where a detainee has been arrested as officially accused, or is not interviewed, it is unlikely that a PIRoS will be recorded. From our examination of custody records, we found that a PIRoS form had been completed appropriately for all detainees where relevant.

91. Because of their size, Govan and London Road custody centres always have a sergeant on duty. 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. The final decision for the sergeant, is to consider the disposal for each detainee and accompany that with a detailed rationale recorded on the NCS. Each record that we examined had a satisfactory rationale recorded to justify the test of necessity and proportionality for arrest.

92. In practice, only those who are arrested as not officially accused, or under suspicion, are the subject of scrutiny by the custody review inspector (CRI) – with reviews taking place at six and 12 hours. These reviews demand that investigation is diligent and expeditious. After an investigation is complete, a detainees status may change to 'officially accused'. An officially accused person in custody is not monitored by the CRI and there appears to be little scrutiny by sergeants to ensure when a decision is made to release a detainee, liberation from custody is not unduly delayed.

93. Our NCS review found six cases where there was an extended delay in a detainee being released following a disposal decision being made. One individual was detained for nine additional hours and another for an additional fifteen hours, with no rationale recorded on NCS to justify the delays. Whilst there may be medical or intoxication issues that justifiably delay release, none of these cases were the subject of a 6 or 12 hour investigative review, and there was no explanation of the necessity to delay their release on records.

94. Overall, there appeared to be a lack of emphasis and urgency regarding release, with staff interviews indicating that mounting workload pressures were often the cause for such delays. Liberty is a fundamental human right and decisions to delay that right must be supported by a clear and robust rationale that provides justification as to the legitimacy of the legal grounds to an extent that they stand scrutiny in a court of law.

95. We made reference to this issue in our recent report on the inspection of custody centres in Ayrshire. **Recommendation 1** from that report states:

"Police Scotland should review compliance with policy relating to the delay of release following a disposal decision being made and ensure that staff adhere to this."[17]

96. It is of concern that despite our previous recommendation, changes to practice in this regard have not been embedded more widely across custody centres. We anticipate that the aforementioned recommendation will be given due attention and actioned accordingly. We will continue to examine progress against the recommendation during forthcoming custody inspections.

[17] HMICS, Custody Inspection Report – Ayrshire, Recommendation 1, 30 May 2024.

97. The average time spent in police custody within our sample was just over 21 hours. However, this includes one record where the detention period exceeded four and half days due to a person being arrested in England. Another was held for almost four days having been arrested in Northern Ireland. Both were subject to lengthy and time consuming transfers to Scotland by GEOAmey, who have the contract to transfer detainees arrested in England, Wales and Northern Ireland to court in Scotland.

98. There were nine further records where the period of detention exceeded two days. All related to the detainee being held over a weekend to appear at court. It is of note that these periods of detention do not include time held in Sheriff Court cells, which typically adds a further six hours before a custody court sits – ordinarily at 14:00 hours.

99. These scenarios lend support to the assertion that were custody courts in a position to sit during weekends, detainees would be far less likely to be subject of extended periods of police detention. This would, in turn, potentially improve the physical and mental wellbeing of detainees, many of whom are classified as highly vulnerable.

100. Furthermore, should courts operate at weekends, custody healthcare providers would also benefit as they would face significantly reduced weekend demand within the custody setting. This could result in finite resources being diverted elsewhere.

101. These changes to court provision would require a significant alteration of established practice for criminal justice organisations including Scottish Courts and Tribunal Service, COPFS, GEO-Amey and other partners. That said, the imposition of necessary alterations to operating models, as experienced during the COVID-19 pandemic, demonstrates that such change is not unprecedented and within reach.

Risk assessment and care plans

102. 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.

103. Effective risk assessment is vital to ensure that detainees can be managed and cared for appropriately. These questions are personal in nature and we saw that staff were sensitive and respectful in their approach. The questionnaires were consistently completed well. We saw risk assessments and care plans being formulated though discussions between the CJPCSO and the team leader or sergeant. A vulnerability assessment was completed in almost all cases within our sample.

104. The 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 should be 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. This level can also be enhanced by the addition of CCTV observation of the detainee in their cell, with images appearing on a monitor in the staff and/or supervisor's office.
- **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.

105. Team Leaders and supervisors have other tactical options to mitigate risk. For example, a referral can be made to a healthcare provider, the detainee can be provided with anti-ligature clothing, or can be placed on enhanced observations. Enhanced observations, means that the cell CCTV images are streamed live to a monitor in the custody office for staff to view occasionally as they carry out other tasks. It is a less intrusive but resource intensive option compared to the above noted Level 3 observations – although policy indicates that it should be accompanied by 15 or 30 minute observation cell visits.

106. Our review of records found that 33 per cent of detainees were intoxicated on arrival at custody. Forty three per cent disclosed a mental health condition, and 32 per cent reported they had previously self-harmed or had attempted suicide. Forty nine per cent were on prescribed medication, and 20 per cent stated they had difficulty with reading and writing. The vast majority, just over 90 per cent, had some form of criminal or police information record.

107. These statistics are similar to those found in our previous joint custody inspections and reflect a correlation between health, vulnerability and offending, which is reasonably consistent across the country. It highlights the high level of risk, addiction, mental health, and medical health challenges presented to police custody on a daily basis.

108. The vulnerability risk assessment of 34 four detainees in our sample was assessed as high and 54 were deemed to be low. In many instances, there was a comment on NCS to explain why a high risk decision was made, but not all. There were a variety of reasons recorded, which included current and historical mental health conditions, medical conditions, intoxication levels, the need for prescribed medicines and presentation. The quality of care plan recording was mixed. One record missed a referral to healthcare, and two records had no risk assessment or care plan. We found the recording of rationale to be inconsistent.

109. Of the 34 detainees assessed as high risk, 22 were placed on Level 1 observations. This reflects an ongoing pattern of custody practice that has been raised with senior custody managers. We have also made recommendations in this regard in recent custody inspection reports. We will continue to monitor progress against these recommendations during forthcoming custody inspections.

110. We also examined the time differences between cell visits being undertaken by custody staff and the time that these were recorded on NCS, and noted some significant delays. While some of these were recorded in good time, in some cases the delay was lengthy, with the longest of these being 86 minutes. This type of delay can result in important information not being available to all staff when required, and has the potential to introduce risks.

111. This matter has been the subject of previous HMICS recommendations where the ability to make contemporaneous records of interactions with detainees using an electronic 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."[19]

Recommendation 3 from our joint custody inspection report on Lanarkshire stated:

"Police Scotland should ensure that processes for recording cell checks are carried out consistently and recorded on the national custody system timeously."

We consider these recommendations to continue to have relevance for practice across all custody centres.

112. When staff are relieved at the end of duty by the following shift, it is considered appropriate to conduct a handover meeting to discuss the risks and ongoing issues relative to the custody centre and detainees. This review discussion should be recorded onto the corresponding NCS record. Sergeants must review the criminal justice decisions and satisfy themselves that the grounds for a given decision remain. Supervisors and staff must familiarise themselves with the risk and vulnerability assessment of each detainee in custody, their presentation and any matters that impact on their safe care. These handover discussions should be documented on the NCS.

113. In our analysis we found that the recording of a handover on the NCS appeared in the majority of records. We noted 12 records without a recorded handover where we consider one should have been present.

[19] HMICS, North East Scotland Custody Inspection, Recommendation 1, 14 December 2021.

Detainee care

114. We interviewed eight detainees across the centres during our inspection. All provided complimentary feedback about their treatment by custody staff and the arresting officers. They had been provided with their rights and stated that custody staff had been respectful and made regular enquiries about their wellbeing.

115. Almost all detainees were provided with food as required, but we noted that there was no reference to the provision of a drink in 33 records. While this is very likely to be a lack of recording rather than a lack of provision, records should be updated more efficiently. Detainees were typically offered a wash in the morning prior to attending court. Those being released to return home were not generally offered a wash or shower, although where requested, this was largely accommodated.

116. No detainees were recorded as having had exercise despite Govan custody centre having a designated exercise area. Staff stated that they do not have time to supervise exercise. There was no reference to the provision of reading materials in the majority of records, however there is no specific field on the NCS for this.

117. Where considered appropriate, detainees should be asked if they would like to be referred to a third sector agency to provide them with support on issues such as addiction, mental health, or if they formerly served in HM armed services. The availability of support services differs from area to area, however, NCS has a compulsory field that staff must update to indicate if the offer was accepted, declined or was not appropriate.

118. The offer of a referral to a third sector agency for support was offered and declined in 45 cases from our sample. The NCS was updated on 45 all of these instances as being not applicable although, in ten cases, there was evidence of substance use and mental health issues suggesting that a referral could have been appropriate.

119. Despite this apparent inconsistency, local policing officers said they had observed custody staff actively promoting the use of third sector arrest referral options in Govan and London Road custody centres. Referrals can be made to the Positive Outcomes Project, which is a service where workers attend the custody centres each week to offer support with homelessness and addiction, and can act as a signposting service for other agencies and services.

120. A referral to a healthcare professional was made in 36 cases, and the NCS indicates that an HCP was contacted in each instance.

121. Medication was required in 24 of the records inspected. For the most part, the NCS was updated appropriately. In one case we saw medication described as other, rather than being described accurately, however this was not common.

Audit of custody records

122. At the time of our inspection, custody review inspectors (CRI) had responsibility for the review of detainees with not officially accused status, however we were informed that they were about to take on live-time audit and review responsibility for all records. Each police inspector in the criminal justice services division (CJSD) should also audit one custody record per week. This represents a very small sample from which to audit and scrutinise compliance. We made a previous recommendation in relation to this issue in our joint inspection of custody in Argyll and West Dumbartonshire[20] and are aware that CJSD are actively making arrangements to address the recommendation.

Staff training

123. All custody supervisors and staff had completed two mandatory custody related courses lasting a total of five days. This includes a custody officer induction course, lasting three days, and two days NCS training. They are also trained in first aid, officer safety, fire safety, food hygiene and data protection. Some staff are trained in CHS and PNC, which is hosted at the police training centre in East Kilbride, and is a residential course.

124. While we welcome this standard being met, we have outlined additional training requirements through recommendations made in our previous reports. We have highlighted that training custody staff in issues including substance use, mental health, trauma informed care, and undertaking detainee observations, would enhance their ability to meet the needs of vulnerable individuals more effectively.

[20] HMICS, Custody Inspection Report – Argyll and West Dunbartonshire, 24 October 2024.

125. Inspectors were informed that all custody sergeants and constables had received training to administer Naloxone.[21] 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. It was positive to note that Naloxone was available for use and, under the current operating model, a sergeant or constable is always available at the centres.

Healthcare

Governance

126. The Glasgow City Health and Social Care Partnership (HSCP) hosts police custody healthcare on behalf of NHS Greater Glasgow and Clyde (GGC), and is responsible for the delivery of healthcare in that area, which includes London Road, Govan, and Cathcart. The service is nurse led with support from forensic medical examiners (FMEs).

127. The police custody healthcare team consists of a peripatetic nursing and medical service. Custody nursing staff were available 24/7, and are on duty over a 24 hour period. The nursing team had a combination of Adult Health Nurses (RGN) and Registered Mental Health Nurses (RMN), who were trained to support the physical health, mental health and drug and alcohol support requirements for all detainees referred to the service. Patients would therefore receive care responsive to their individual needs. We considered this to be good practice.

128. An FME was also available on call. At the time of inspection, there were no staff vacancies. Gaps in nursing rotas are covered by existing healthcare staff or by Glasgow's Sexual Assault Response healthcare staff from Coordination Service, as they had completed the relevant forensic competencies.

129. Healthcare was well managed, with the HSCP providing a clear management structure, monitoring and oversight through its clinical and care governance processes. Staff spoken with described the management team as visible and supportive.

[21] 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.

130. Regular governance meetings and multiagency meetings took place between NHS and Police Scotland. This enabled contingency planning in advance of any changes that could occur operationally, such as planned opening or closing of custody centres.

131. An induction programme for all new healthcare staff was available. Training records showed good compliance with mandatory and role specific training, which included equality and human rights, the Istanbul Protocol[22] and trauma informed practice.

132. Clinical supervision was available and was carried out monthly by the Senior Charge Nurse. Staff also had access to peer supervision to discuss complex cases and reflect on practice. The non-medical prescribers[23] held regular peer group meetings to discuss updates, concerns and medications. We were told all FMEs had an annual appraisal which was recorded. FMEs held regular review meetings with colleagues to discuss challenging cases.

133. There was information displayed in all custody centres about how detainees could make a complaint or give feedback. At the time of inspection, there had been no complaints received in the past 12 months. The DATIX[24] risk management information system was used appropriately to report incidents. There was evidence that staff were confident to report incidents, a practice that was embedded within practice. These were discussed at clinical governance meetings.

134. Treatment rooms in all centres were visibly clean and in a good state of repair, with hand wash basins and personal protective equipment available for use. Flooring, work surfaces, and ceilings were all intact ensuring effective cleaning could be carried out. An external cleaning company had access to clean the treatment room floors. Healthcare staff undertake cleaning of the surfaces and medical equipment after each use of the treatment rooms. An appropriate chlorine-based cleaning product was available in line with current guidance. Cleaning of the cells and custody areas in all centres, including the management of blood or body fluid spillages, was completed by an external company.

[22] OHCHR, Istanbul Protocol, 29 June 2022.
[23] Non-medical prescribing (NMP) is the term used to describe any prescribing completed by a healthcare professional other than a doctor or dentist.
[24] Datix system is an online system for all healthcare staff to report any incidents and risks.

135. Sharps bins used by NHS staff were correctly labelled and had temporary closures in place. The contract for the larger sharps bins (over 30 litres) is with NHS GGC. Police Scotland manage the smaller sharps bins (under 30 litres), and as indicated previously in this report, these need to be managed more effectively. Clinical waste was disposed of in line with guidance. Inspectors saw that clinical waste and larger sharps bins in both sites were stored in a locked secure area.

136. 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 lined was stored securely while awaiting collection.

137. There was an identified infection prevention and control (IPC) lead for the custody centres and a programme was in place to complete monthly IPC audits. Training records showed all healthcare staff had completed IPC training.

138. Systems and processes were in place to manage medical emergencies. Emergency equipment which included oxygen, the suction machine and automated external defibrillators, were available with regular checks being completed. However, at the time of our inspection, it was noted at London Road that the oxygen mask within the emergency bag and the defibrillator pads had expired. All healthcare professionals were trained in basic life support.

Recommendation 5

Glasgow City HSCP should ensure that expiry dates on all equipment at the custody centres are checked to ensure that equipment is within date and ready for use.

Access to healthcare

139. 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.

140. There is no nationally agreed waiting time standard for healthcare assessment of individuals detained in police custody centres across Scotland. However, the service operated a model where all referrals from Police Scotland would be triaged, reviewed and prioritised at a central hub at the Govan centre and an assessment would be completed, primarily by the nursing team. Waiting times could vary depending on the number of detainees in custody and the information gathered from the triage assessment.

141. London road has the third highest volume of detainees nationally. Interviews with custody staff at London Road highlighted frustrations at perceived delays in nurses attending the custody centre as all nurses are based at the Govan hub.

142. Detainees could also request to see healthcare staff at any point. Information regarding healthcare was included in the booklet ‘Your rights when you are at the police station’, which 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 at the charge bar area of Cathcart and Govan custody centres but not London Road.

143. Staff reported slow responses from nurses and cited one case where a nurse would not attend for a detainee held under not officially accused status. It is considered this may be a conflation with existing medical policy not to medicate detainees within the first six hours. There seemed to be some confusion amongst staff about whether there was a formal NHS policy position on this or if it had just emerged over time as a practice approach.

144. NHS GGC managers highlighted that detainees with not officially accused status potentially requiring healthcare were assessed on a case-by-case basis and that there was no blanket response. However, in the interests of clarity, custody and healthcare staff operating in the centres should be provided with a clear position on this.

Recommendation 6

Glasgow City HSCP should provide custody and healthcare staff with clarity on its position and practice expectations regarding the assessment of detainees with not officially accused status.

145. In collaboration with healthcare partners, CJSD had produced guidance for custody staff on their roles and responsibilities regarding maintaining patient confidentiality for detainees when undergoing intervention and treatment by the healthcare team. Inspectors were told that this was being followed and monitored in all centres, with clinical examinations generally carried out in a dedicated treatment room. Inspectors were advised that the door to the treatment room would be closed unless custody staff had highlighted this as a safety risk.

146. The separate electronic systems used by custody staff and NHS staff to record custody data were unable to connect with each other to share information. Custody staff use the NCS to record information relevant to detainees, whereas NHS staff use Adastra.[25] Healthcare related recommendations were emailed to the generic custody email and then copied onto NCS.

147. NHS 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.

148. There were two accessible cells available at London Road custody centre but none were available at Cathcart or Govan police custody centres. Detainees with any mobility issues who could not be managed at Cathcart or Govan would be transferred to another custody centre.

[25] 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.

149. There was evidence of a Child and Adolescent Mental Health Service (CAMHS) pathway in place for referring children to specialist services if required. Both police custody and healthcare staff advised this was an effective pathway that enabled young people to be seen and specialist advice could be sought.

150. There were also links with local children's social work teams for young people and children detained in custody.

Medicines management

151. The service had a range of policies and standard operating procedures to support staff with the safe supply, storage, dispensing and safe destruction of medicines. There was also a pharmacist with responsibility for supporting the governance of medicines management in all the custody centres.

152. All medicines, including controlled drugs, were stored securely in locked cabinets and locked medicine fridge in the treatment rooms. The keys for the medicine cabinets and fridge were kept in a key safe that only healthcare staff could access.

153. Medications were prescribed by non-medical prescribers and FMEs. Various methods were used to ensure robust medication reconciliation, including checking the Emergency Care Summary (ECS), speaking with the patient's GP and local pharmacist. This ensured that patients received their normal medication whilst detained, including any Opiate Substitution Therapy (OST). Systems and processes were in place to obtain patient's medication from their home address or community pharmacy where required.

154. Controlled drug registers were completed well with no gaps or scoring through. There was evidence of stock and balance checks being completed.

155. Processes were in place for medications to be administered by custody staff from compliance aids, apart from OST, which was administered by healthcare staff. The compliance aids in all custody centres were held securely by custody staff in a locked safe until they were required. We checked several stock medications and found these to be in date with evidence of stock management.

156. Inspectors reviewed incidents recorded, which included medication errors by custody staff, however, there was evidence of appropriate review at both Glasgow City HSCP's healthcare clinical governance meetings, and by Police Scotland service reviews with action taken and any learning shared with staff at team meetings and by email.

Substance use

157. The vulnerability questionnaire used by custody staff included questions regarding the use of alcohol or substances and whether detainees had substance dependency. Nursing staff assessed detainees who appeared to be under the influence or withdrawing from alcohol or substances. They had access to the appropriate tools for monitoring withdrawals, carrying out physical observations and prescribing detoxification medication where required.

158. Processes were in place for confirming, collecting and administering community prescriptions for patients within custody who were prescribed OST. For patients appearing in court, OST was not routinely given prior to attending. However, we were told detainees were consistently leaving for court early in the morning and communication systems were in place for OST to be administered to patients upon release through community pharmacy services to ensure continuity of OST. Plans were being progressed to have stock methadone within the custody centres, which could reduce the time taken for custody staff to obtain prescriptions and reduce the requirement for daily prescribing over the weekend.

159. 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. An initial baseline exercise was undertaken to identify where developments could be made towards implementing MAT, however, there are further considerations being made at board and national level regarding what is required within police custody settings.

160. Data recorded showed a range of harm reduction information and interventions were available to detainees in all custody centres with good uptake. BBV[26] testing was available to all detainees accessing healthcare in custody. All healthcare professionals had access to Naloxone[27] and were trained to administer it. Inspectors were told police sergeants and custody constables were trained and had access to Naloxone, therefore there would always be someone available to deliver Naloxone when required. Take home Naloxone kits were also available to detainees.

161. There was a process in place for nicotine replacement therapy to be made available. Detainees we spoke with provided feedback that they received this, where required.

Mental health

162. Custody staff at the centres can request nursing staff to undertake fitness for court, release, and detention assessments. Inspectors viewed a standardised assessment tool used to record assessments, which included the patient's history, details of examination, assessment and recommendations.

163. A standardised risk assessment tool was available for healthcare staff to identify people at risk of self-harm or suicide. Inspectors were told this was completed for patients receiving mental health assessments, where patients are referred to community mental health services, and where patients require admission to specialist mental health units. Risk management plans were shared with custody staff in line with recommendations made by healthcare staff. This included enhanced monitoring or observation levels where there was a concern for a patient's wellbeing.

[26] A blood borne virus (BBV) is an infection that can be transmitted from one person (the donor) to another through direct contact of bodily fluids, especially blood.
[27] 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.

164. A process was in place for patients requiring transfer to hospital following a mental health assessment. Inspectors were told the process was well established and generally transfers could be arranged, where required, without an issue when there was no requirement for the person to attend court.

165. Custody data showed that the custody centre was rarely used as a place of safety under section 297 and 298 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

166. While the RMNs generally respond to referrals for patients requiring mental health assessments, RGNs also saw patients at the custody centres. Training opportunities were available to ensure staff competencies including access to mental health first aid, skills training in self-harm, suicide prevention and intervention. This is considered good practice.

167. Detainees with learning disabilities could be identified from the vulnerability questionnaire and through screening the vulnerable persons database. Systems were in place to involve an appropriate adult service if required. Healthcare have delivered training to CJPCSOs on a variety of topics, including learning disabilities, mental health, neurodiversity and physical health, which we consider good practice.

Pre-release pathways and referrals

168. When a detainee is transferred from a custody centre to court, a Person Escort Record (PER) form is completed. This form contains information regarding the detainee's medical condition and medications and is taken from the NCS.

169. There was evidence of signposting detainees to community support services and custody staff were knowledgeable about the support available in the community. A range of leaflets and posters were displayed for mental health, substance use, health and wellbeing, harm reduction, peer support and family support available in the community.

170. Guidance for healthcare staff regarding onward referrals to community services was available within standard operating procedures for community mental health teams and substance use services.

171. Healthcare staff also had processes in place to communicate with community pharmacies, community mental health and substance use services where required for continuity of care.

Detainee transfers

172. The escort provider, GEO-Amey attend at London Road and Govan custody centres each morning to take detainees to Glasgow Sheriff court. Detainees destined for other courts can wait longer but this was not considered to be an issue of concern. Staff did explain however that there were challenges with the uplift of detainees who require a further medical review, those on constant observations or otherwise needing a special uplift. These detainees can often remain at the custody centre well into the afternoon. This is a pattern that has been reported in our previous custody inspections. It causes delays in cleaning cells, creating capacity, and can add to ongoing medical needs.

173. Staff at Govan referred to challenges caused by video identification parades (VIPER) operated from the centre. This usually involves a remand prisoner being brought to the custody centre from prison by GEO-Amey. Whilst there is an expectation that GEO-Amey staff would remain, as they retain responsibility for the individual, the staff are often deployed elsewhere. Consequently, the remand prisoner is lodged in a police cell and cared for by police custody staff, but without the normal privileges afforded to a remand prisoner. They can remain in this setting for several hours, which results in additional challenges for custody staff.

Local policing

174. Inspectors interviewed local policing officers, in various roles, who utilise custody services. Some highlighted that abstractions to perform constant observations drew them from other duties; others stated that delays in booking-in were the most problematic issue.

175. Local detective officers based at Govan stated they tend to maintain a personal stock of forensic swabs as they have frequently encountered situations where local stations in Greater Glasgow have depleted supplies. This was also reflected in comments from local police response officers. Feedback was provided to custody supervisors.

176. A local policing officer described a scenario relating to a CJPCSO insisting on conducting a risk assessment prior to lodging a disruptive detainee in a cell. The officer was of the opinion the person could have been lodged first to enable them to calm down, with a view to carrying out the risk assessment later in the shift. While the officers perspective can be understood, the strict adherence to booking-in policy is the correct procedure and it is positive to see this being adhered to, even in challenging circumstances. It demonstrates a focus on, and understanding of, the care and welfare needs of the detainee, who's behaviour could potentially have been as a consequence of experiencing a medical issue, or mental health episode.

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978-1-910165-88-1

HMICS/2025/01