HMICS

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND

Inspection of custody centres across Scotland

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Improving Policing Across Scotland

npm national preventive mechanism

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HM Inspectorate of Constabulary in Scotland

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

We have 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, we can be directed by Scottish Ministers to look into anything relating to the SPA or Police Scotland as they consider appropriate. We also have an established role in providing professional advice and guidance on policing in Scotland.

- Our powers allow us to do anything we consider necessary or expedient for the purposes of, or in connection with, the carrying out of our functions
- The SPA and the Chief Constable must provide us with such assistance and co-operation as we may require to enable us to carry out our functions
- When we publish a report, the SPA and the Chief Constable must also consider what we have found and take such measures, if any, as they think fit
- Where our report identifies that the SPA or Police Scotland is not efficient or effective (or best value not secured), or will, unless remedial measures are taken, cease to be efficient or effective, Scottish Ministers may direct the SPA to take such measures as may be required. The SPA must comply with any direction given
- Where we make recommendations, we will follow them up and report publicly on progress
- We will identify good practice that can be applied across Scotland
- We work with other inspectorates and agencies across the public sector and co-ordinate our activities to reduce the burden of inspection and avoid unnecessary duplication
- We aim to add value and strengthen public confidence in Scottish policing and will do this through independent scrutiny and objective, evidence-led reporting about what we find

Our approach is to support Police Scotland and the SPA to deliver services that are high quality, continually improving, effective and responsive to local needs.[2]

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

[1] Chapter 11, Police and Fire Reform (Scotland) Act 2012.
[2] HMICS, *Corporate Strategy 2017-20* (2017).

Contents

Our inspection

The aim of this inspection was to assess the treatment of and conditions for those detained in police custody centres across Scotland. We inspected 17 custody centres and assessed what progress has been made in achieving positive outcomes, adhering to national policy and processes, and implementing previous HMICS recommendations.

Each inspection of police custody carried out by HMICS contributes to the United Kingdom's response to its international obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by a National Preventive Mechanism (NPM), an independent body or group of bodies which monitor the treatment of and conditions for detainees. HMICS is one of several bodies making up the NPM in the UK.[3] To effectively carry out their role, OPCAT requires that NPMs be independent and that conflicts of interest among staff members are avoided. HMICS has therefore committed to ensuring that any police officers who may be seconded to work with us do not form part of our custody inspection team.

Police custody is a high risk area of policing business and, as such, has already been subject to considerable scrutiny by HMICS since Police Scotland was established. Since 2013, HMICS has published six custody inspection reports. The first of these, a thematic inspection of arrangements for police custody, was published in 2014.[4] It reported on the national arrangements for the delivery of police custody and drew on evidence gathered about treatment and conditions in custody during inspection visits to 22 custody centres across Scotland. The thematic inspection was followed by five inspections of police custody in particular areas, usually linked to inspections of local policing divisions.[5] Taken together, these inspections resulted in 27 recommendations and 47 improvement actions.

Our inspections are based on an inspection framework which ensures a consistent and objective approach to our work. The framework consists of six themes:

- Outcomes
- Leadership and governance
- Planning and process
- People
- Resources
- Partnerships

Each theme is supplemented by a range of indicators setting out what we expect to find during our inspection. In relation to custody, the 'outcomes' theme features additional indicators specific to custody. This inspection focused on these custody-specific indicators, which relate to the treatment of and conditions for detainees, and drew on evidence gathered from our inspections of 17 custody centres. Our inspections of the 17 centres also allowed us to gather evidence about the broader aspects of our inspection framework. This evidence will be used to inform a second inspection of custody later in 2018-19 which will involve HMICS assessing the strategic direction for the future delivery of Police Scotland's custody arrangements, including consideration of our broader inspection framework. This will also allow us to assess the significant improvement activity that has taken place within custody in recent years.

[3] For more information about the UK NPM, visit www.nationalpreventivemechanism.org.uk.
[4] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014).
[5] HMICS, *Inspection of custody centre located in Aberdeen City Division* (2015); *Inspection of Edinburgh Division* (2015); *Inspection of Dumfries and Galloway Division* (2016); *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016); *Inspection of custody centres located in Tayside Division* (2018).

Our inspections of each of the 17 custody centres were unannounced and took place in May and June 2018. During our visits, we assessed the physical environment, interviewed detainees,[6] custody staff and other professionals working in the custody centre (such as solicitors or doctors) and observed key processes such as detainees being booked into or released from custody and shift handovers. We also reviewed the custody records of 145 people who had been detained in police custody across the 17 centres.

Our visits commenced at various times of the day including early morning and late evening, and several took place at weekends when custody centres are typically busier. We visited some centres on more than one day in order to assess how the centres operated at different times, to speak to staff on different shifts, and to speak to and observe how detainees were managed where there had been no detainees present on our initial visit. Three of the centres were not holding detainees at the time of any of our visits. Several of the centres we visited were located in island or rural locations and typically have a low throughput of detainees. Our findings may reflect the more remote nature of some of the centres visited and their lower throughputs, compared to our thematic inspection in 2014 where many of the centres inspected were in busier, urban locations. With the exception of Elgin, none of the 17 custody centres visited have been inspected by HMICS since the creation of Police Scotland.

In addition to inspecting custody centres, we sought the views and experiences of independent custody visitors and consulted with other stakeholders, including in relation to the implementation of the Criminal Justice (Scotland) Act 2016.

HMICS would like to thank all those who participated in and facilitated our inspection. The inspection was led by Laura Paton, supported by Tina Yule, Stephen Whitelock (all Lead Inspectors), Annie Crowley and Davie Flynn (Associate Inspectors).

Gillian Imery QPM
Her Majesty's Chief Inspector of Constabulary
October 2018

[6] The term 'detainee' is used throughout this report to refer to all people held in police custody, regardless of the reason for which they are being held or their status, for example, as an officially accused or not officially accused person.

Key findings

- Across the 17 custody centres we inspected, staff were committed to providing a good standard of care for those held in police custody, many of whom are vulnerable and with significant health care needs.
- The quality of the custody estate varies significantly across Scotland and, in some areas, hampers the effective and efficient management of detainees. Police Scotland has not yet developed a custody estate strategy.
- While progress has been made in achieving consistent processes and practice in custody centres across Scotland since the creation of Police Scotland, some inconsistencies persist.
- There are opportunities for greater partnership working between Police Scotland and other statutory and voluntary sector organisations to best meet the needs of today's detainee population.
- The absence of scrutiny of the delivery of health care in police custody by the NHS limits the potential for better outcomes to be achieved for detainees.
- There is greater awareness than previously of the need for privacy when booking detainees into police custody.
- While risk assessments and care plans are often of a high standard, in too many cases it is not clear (or not clearly recorded) why a detainee has been assessed as low or high risk and the rationale for the subsequent care plans is not always apparent. This remains a recurring theme in our inspections of police custody.
- The conduct of constant observations of high risk detainees could be improved.
- There is some confusion among custody staff as to whether a parent, guardian or other appropriate adult should be present when young people under the age of 18 are being strip searched.
- Police Scotland has begun to analyse data on use of force but there is a need to improve recording and conduct more trend analysis to ensure force is not being used disproportionately in some areas or against detainees with particular characteristics. Data should also be published to allow for greater transparency.
- Efforts are made to meet the diverse needs of detainees, however gender sensitive care could be improved. In particular, there is a need to better meet the needs of menstruating women in police custody.
- Following the introduction of the National Custody System, there are opportunities for Police Scotland to use data more effectively to plan its custody service and inform resourcing decisions.
- Staff working in custody are professional and respectful. Detainees told us they had been treated fairly.
- The quality of Person Escort Records has generally improved, but useful information is still missing in a small number of cases.
- While Police Scotland has introduced guidance on custody transfers, we heard concerns from custody staff that some detainees are inappropriately selected for transfer.

- Police Scotland continues to face challenges in matching demand with the available custody estate – some areas are under provisioned and some areas are over provisioned.

- The requirements of the Criminal Justice (Scotland) Act 2016, implemented in January 2018, are being met. We found good recording of the reasons why a person continued to be held in custody.

- There is scope for Police Scotland and other criminal justice organisations to improve the legal assistance and information provided to detainees.

- Custody throughput has continued to fall in recent years, but the duration of a person's time in custody stayed broadly similar before and after the 2016 Act came into force.

- There is a need for some appropriate adults to have greater awareness of their role and improved training in supporting vulnerable people. Custody staff would benefit from training in identifying people with learning difficulties so that the assistance of an appropriate adult is sought when necessary.

- Independent custody visitors often experience unnecessary delays in gaining access to custody centres.

- Arrangements for the delivery of health care in police custody vary across Scotland. Access to timely health care can be problematic in some areas.

Recommendations

Recommendation 1
Police Scotland should develop its custody estate strategy as a matter of urgency in order to address variations in provision across the country and better meet demand.

Recommendation 2
Police Scotland should improve its systems to eliminate unnecessarily inconsistent processes and practice in custody.

Recommendation 3
Police Scotland should address outstanding HMICS recommendations as soon as possible with a view to improving the delivery of custody.

Recommendation 4
Healthcare Improvement Scotland and the Scottish Government should ensure that the delivery of health care in police custody is appropriately scrutinised so as to improve outcomes for detainees.

Recommendation 5
Police Scotland should provide further guidance and training to staff on carrying out effective risk assessments and ensuring care plans manage the risks posed. Staff should also be reminded to record the rationale for risk assessments and care plans.

Recommendation 6
Police Scotland should ensure there are appropriate safeguards in place when strip searching children under the age of 16, and 16 and 17-year-olds, in police custody.

Recommendation 7
Police Scotland should publish force-wide data on the use of force.

Context

1. Police Scotland's Criminal Justice Services Division is responsible for delivering custody across Scotland. It is one of several national divisions which sit alongside and support the 13 local policing divisions and was established in 2013 to promote consistency in working practices across custody centres in Scotland. The division is led by a Chief Superintendent, who reports to an Assistant Chief Constable[7] and, in turn, to the Deputy Chief Constable with responsibility for local policing. Custody is delivered in accordance with the custody standard operating procedure (the 'custody policy').[8]

2. Custody centres across Scotland are organised into clusters, each led by an inspector. Currently, there are 79 custody centres organised into 12 clusters. There are three types of custody centre – primary, weekend only and ancillary. Primary centres are permanently staffed and are open to receiving detainees at any time. They are operated by custody staff from Criminal Justices Service Division. Weekend only centres operate in a similar way to primary centres but are only open to receiving detainees between a Friday and Monday. Ancillary centres are those which are used only when needed. They are often located in rural or island areas, and are staffed by local policing officers who have received custody training. The number of people detained (the 'throughput') at ancillary centres is generally lower than that at primary centres. Custody centres are led by the custody supervisor who is generally a sergeant, although there are an increasing number of constable-led custody centres.

3. We inspected 17 centres located in eight of the 12 clusters. These centres were spread across eight local policing divisions and 13 of Scotland's 32 local authority areas. Twelve of the centres inspected were primary centres, and five were ancillary centres.

Custody centre	Type	Number of cells	Annual throughput 2017-18
Ayr	Primary	15	2,258
Campbeltown	Primary	10	153
Coatbridge	Primary	24	4,458
Dunfermline	Primary	18	2,827
Dunoon	Primary	10	335
Elgin	Primary	14	2,123
Fort William	Ancillary	8	332
Greenock	Primary	57	3,971
Hawick	Primary	10	1,157
Kirkwall	Ancillary	6	206
Lanark	Primary	6	1,138
Lerwick	Ancillary	6	280
Lochgilphead	Primary	3	108
Oban	Primary	7	401
Saltcoats	Primary	21	2,913
Stornoway	Ancillary	7	232
Wick	Ancillary	5	379

4. In advance of our visits to each of the custody centres, we reviewed a sample of custody records of people who had been detained there during the previous month. The size of the sample was proportional to the annual throughput of detainees and was purposively selected to be broadly representative of the proportions of men, women, children and foreign nationals held at those centres in the last year. We did not purposively sample records relating to other protected characteristics either because the characteristics had not been recorded or because we were less confident that the data had been recorded accurately. We reviewed 145 custody records in total.

[7] The custody portfolio is currently held by the Assistant Chief Constable (Local Policing East).
[8] Police Scotland, *Care and welfare of persons in police custody – standard operating procedure* (2018).

Outcomes

5. Across the custody centres we inspected, staff were committed to providing a good standard of care for those held in police custody, many of whom are vulnerable and with significant health care needs. Staff deliver care in often challenging circumstances and should be commended for their professionalism. Nonetheless, their ability to deliver effective and equitable support to detainees held in custody centres across Scotland can be hampered by factors outwith their control including the quality of the custodial environment in which they work, sufficient resources, and assistance from partner organisations who may be better placed than the police to provide the support which detainees most need. Underpinning many of the findings outlined in this report are recurring themes which present challenges in delivering a custody service that best meets the needs of today's detainee population.

6. Firstly, the quality of the custody estate varies significantly across Scotland and, in some areas, hampers the effective and efficient management of detainees.[9] This includes centres which are of poor quality as well as centres which have insufficient capacity to meet local demand. Police Scotland inherited its estate from eight legacy forces, each of which made decisions about the location and capacity of its custody centres taking into account local demand and priorities. Much has changed since those decisions were taken, including a reduced demand for custody, an increased recognition of and improved response to the needs of vulnerable detainees, evolving custody standards, structural changes in how custody is delivered, and changes in the legal framework for custody, such as the Criminal Justice (Scotland) Act 2016.

7. Fundamentally, some high quality centres are little used while some poor quality centres are in areas of high demand. For example, the custody centres at Fort William and Campbeltown are high quality centres where investment by legacy forces has resulted in modern facilities that are well equipped to help staff manage detainees efficiently and effectively. However, Fort William is an ancillary centre with no permanent custody staff, while Campbeltown has one of the lowest throughputs of a primary centre in Scotland. Also in the Argyll area, Oban is a primary custody centre with more than twice the throughput of Campbeltown but is one of the poorest centres we inspected and requires significant investment. Similarly, the custody centre at Lanark has one of the highest ratios of throughput per cell in Scotland, yet requires refurbishment and has no CCTV-monitored cells.

8. We also noted anomalies in the status and throughput of custody centres. For example, Lochgilphead had an annual throughput of 108 detainees in 2017-18 and has retained its status as a primary centre, while Wick and Fort William each had three times as many detainees but are only ancillary centres. These anomalies may be linked to whether or not legacy forces employed Police Custody and Security Officers (PCSOs) at those centres, but there is an opportunity for Police Scotland to further review its estate in light of evidence about demand and in consultation with local policing divisions.

[9] For estate limitations see, for example, secure routes to booking in (paragraph 16), privacy at booking in (21), conditions for conducting constant observations (38), facilities for detainees with a disability (46), poor layouts and inadequate facilities (56-57), detainee care (62), lack of showers and exercise yards (66-67), the need to transfer detainees within the custody estate (78), poor facilities for solicitor consultations (86).

9. While Police Scotland has invested in its custody estate and closed centres it deemed unnecessary, challenges posed by the estate remain and cannot be easily fixed without significant further investment. In 2014, we noted that Police Scotland intended to develop a custody estate strategy. We recommended that it be finalised as a matter of urgency and that Police Scotland should work with the SPA and Scottish Government to prioritise investment in the custody estate.[10] Since 2014, a variety of work has been undertaken in connection with the development of the custody estate and there has been investment in improving, for example, solicitor consultation rooms and CCTV coverage. However, no overarching custody estate strategy is yet in place. We have restated the need for a custody estate strategy at Recommendation 1, and future plans for the custody estate will be a key issue for review by HMICS as part of our inspection of the strategic delivery of custody later in 2018-19.

Recommendation 1

Police Scotland should develop its custody estate strategy as a matter of urgency in order to address variations in provision across the country and better meet demand.

10. A second recurring theme in our inspection findings relates to inconsistency in practice across custody centres.[11] Upon the establishment of Police Scotland, a national division was created to deliver custody and promote consistency in working practices across custody centres. Significant progress has been made. For example, all custody centres use the same vulnerability questionnaire when booking detainees into custody, and the introduction of the National Custody System has provided opportunities for increasingly standardised processes. Nonetheless, during our inspection, we were concerned that some inconsistencies in practice persist.

11. While we agree that local deviation from national processes may sometimes be appropriate, this should result in equitable outcomes for detainees, or so as to better meet the needs of local policing. Instead, we have found inconsistencies with no apparent justification, such as variation in how staff meet the needs of women in custody. We have also found variation in standards, such as in relation to hygiene and cleanliness within custody centres. Of particular concern is that some inconsistencies persist even where they have been previously highlighted by HMICS or been the subject of a recommendation.[12] Governance, training, monitoring and internal audit and scrutiny arrangements will be examined in more detail in our review of the strategic delivery of custody to be carried out later this year. Unless a specific custody centre is named, our recommendations relate to all custody centres and Police Scotland should ensure that our findings and recommendations are communicated to all those working in custody.

Recommendation 2

Police Scotland should improve its systems to eliminate unnecessarily inconsistent processes and practice in custody.

Recommendation 3

Police Scotland should address outstanding HMICS recommendations as soon as possible with a view to improving the delivery of custody.

[10] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Recommendation 14.
[11] See, for example, inconsistencies in risk assessments (from paragraph 22), constant observations (39), anti-ligature clothing (40), searches of young people (41), recording use of force (43), cleanliness (59), provision of toilet paper, drinks, showers and other supplies (62-70), lighting (71), pre-release risk assessments (72).
[12] See Appendix 1 for the status of custody recommendations made by HMICS since 2014. Of 27 recommendations, 12 have been closed and one partially closed. Of 47 improvement actions, 26 have been closed.

12. A final recurring theme in our inspection relates to the vulnerability and health care needs of many people in police custody. In 2014, we reported that rather than providing an interim custodial service, Police Scotland is increasingly caring for highly vulnerable individuals with limited policing resources. It is arguable that other services, such as health, social care and addiction services, would be better placed to meet their needs. While the NHS has delivered health care in police custody since 2014, there are opportunities for Police Scotland to work in partnership with other service providers to divert people from custody, and to support them during or after their time in custody.[13]

13. The custody records we reviewed demonstrate the level and complexity of need amongst the detainee population. In 37% of the records we reviewed, the advice or attendance of a health care professional was required. Twenty six per cent of the detainees received medication while in custody and 10% were taken to hospital. At the time of booking in:

- 44% of detainees reported having a mental health issue
- 27% had previously attempted self-harm or suicide and 5% had current thoughts of self-harm or suicide
- 57% were taking prescribed medication
- 15% said they were dependent on drugs and 14% had used drugs in the last 24 hours
- 12% said they were currently withdrawing from drugs and another 12% said they had experienced drug withdrawal in the past
- 5% said they were dependent on alcohol and 34% said they had used alcohol in the last 24 hours
- 19% said they had an injury
- 11% said they had experienced a knock to the head in the last 48 hours.

14. Because of the complex health needs of many detainees, we consider the availability and quality of health care to be a key element in assessing their overall treatment while in police custody. However, given that health care is delivered by the NHS and the role of HMICS is to inspect policing, we are limited as to what assessment we can make about health care in police custody. For that reason, we have been engaging with Healthcare Improvement Scotland (HIS), the regulatory and scrutiny body for the NHS, and the Scottish Government, regarding the development of a joint inspection programme for police custody which would allow the health care provided to detainees to be fully assessed. We consider there to be a pressing need for this joint inspection programme to ensure detainees receive appropriate health care while in custody. The current absence of scrutiny limits the potential for better outcomes to be achieved for police detainees. Both HIS and the Scottish Government are committed to progressing this joint programme for police custody.

Recommendation 4

Healthcare Improvement Scotland and the Scottish Government should ensure that the delivery of health care in police custody is appropriately scrutinised so as to improve outcomes for detainees.

[13] See paragraph 104.

Arrival in custody

15. Section 4 of the Criminal Justice (Scotland) Act 2016 requires police officers to take arrested persons to a police station as soon as is reasonably practicable. Our review of custody records indicated that detainees are generally taken to a custody centre without delay. Detainees arrived at a custody centre within 30 minutes of their arrest in more than 75% of the custody records we examined. In less than 5% of the records, detainees did not arrive until more than 60 minutes after their arrest. While the reason for the delay was not clear in some cases, in others it was because the detainee had first received medical attention, or because the detainee was arrested some distance from the nearest custody centre.

16. Staff seek to manage the arrival of detainees and their escorting to the booking in desk as safely and securely as possible. However, this is made more challenging in some centres due to a lack of appropriate facilities. For example, some of the centres we visited lacked secure vehicle docking areas and were not monitored by CCTV. Some centres did not have secure routes from the vehicle docking area to the booking in desk, and several centres lacked holding rooms, where detainees can be held safely while waiting to be booked in. This meant that detainees would be held in corridors, stairwells or in police vehicles in the yard. These waiting environments pose risks that require to be managed by both arresting officers and custody staff and make it more difficult for custody supervisors to assess which detainees should be prioritised for booking in.

17. We asked custody staff how detainees are prioritised when queues form for booking in. Some staff said it was simply a case of first come, first served, while others said only drunk drivers or violent detainees would be prioritised. We were concerned at the variation in their responses and that some did not consider other known risks or vulnerabilities as part of their assessment.

18. Staff at busier centres told us that queues are now more likely as they feel that booking in takes longer than previously. They attributed this to a combination of factors including the introduction of a more thorough vulnerability assessment, the national custody system taking longer to complete than some legacy systems (particularly when logging a detainee's property) and the processes associated with the Criminal Justice (Scotland) Act 2016, which came into force in January 2018.

Assessing and managing risk

19. During the booking in process, a risk assessment is carried out for every person who comes into police custody. Effective risk assessment is essential so that detainees can be managed and cared for appropriately. A key element of the assessment is the vulnerability questionnaire, when custody staff ask the detainee questions relating to drug or alcohol use, health conditions etc. Custody staff also use information gathered from other sources to inform the risk assessment, such as the observations of arresting officers, checking for warning signals or markers on police systems and checking the division's adverse incident database. The database is a useful tool which holds details of incidents which have taken place in police custody in which a person has been injured or has been at risk of harm.

20. The risk assessment process concludes with custody staff determining a care plan for detainees. This involves assessing whether the individual is high or low risk, and what level of observation they should receive. Under the current custody policy, observations can either be constant, or at 15, 30 or 60-minute intervals. The care plan may also involve seeking medical assistance or other actions designed to safeguard the detainee's wellbeing.

21. In 2014, we commented on a lack of privacy for detainees at booking in desks. Privacy is particularly important due to the sensitive nature of the questions being asked during the booking in process, and the need for detainees to feel able to speak openly about issues such as health conditions. During our most recent visits to custody centres, we noted that while the layout of some booking in areas still poses challenges, staff are more aware of the need for privacy. Often, only one person will be booked in at a time to maintain their privacy (although this can have the effect of increasing queues).

22. During our inspections of the 17 custody centres, we observed several examples of detainees being booked into custody and, in our review of custody records, we considered how information about a detainee was used to inform the risk assessment and care plan. In the cases we observed, we noted staff positively engaging with detainees and asking good follow-up questions in response to the information provided by detainees. However, in our review of custody records, we identified the same issue that we have highlighted in previous reports[14] – that it is not always clear to us from the information recorded why a detainee has been assessed as high or low risk, or why a particular level of observation has been chosen.

23. In the majority of records we reviewed, we agreed with the assessment that the person being booked into custody was either high or low risk. However, in 10% of cases, the information available on the record suggested the assessment was incorrect. In all but one of these cases, the detainee was assessed as low risk but we felt the evidence suggested they were high risk. The incorrect risk assessment often meant the detained person was subject to a lower level of observation than we felt was necessary. For example, in one case, the detainee had consumed an extensive amount of alcohol prior to being arrested but his condition was monitored every 60 minutes (the minimum permissible). We would have expected him to be monitored more often, with observations becoming less frequent as he became less intoxicated.

24. It is possible that when assessing risk, custody staff discount some risk factors with good reason, such as when a detainee reports a suicide attempt many years previously and reassures staff they have no current thoughts of self-harm or suicide. We would expect, however, that such risk factors are addressed when staff are recording their rationale for their risk assessment to demonstrate that they have, in fact, been taken into account. While we see many examples of this being done, it is not routinely done by all.

25. We also noted inconsistencies in risk assessments between centres, and even between shifts. For example, some custody staff would automatically assess a young person as high risk on the basis of their age. Other staff would only assess them as high risk if other risk factors existed. We were also concerned that a small number of staff we spoke to appeared unaware of the adverse incident database which should be checked when booking in all detainees. This was in contrast to most staff who routinely checked the database and used it to inform their risk assessments.

26. In our review of custody records, as well as assessing whether the risk assessment is correct, we also assess whether the subsequent care plan is appropriate. The care plan principally comprises the level of observations set for the detainee, based on the level of risk posed. We were concerned that the level of observations was not appropriate in one fifth of the cases reviewed (including several of the cases highlighted above where we considered the risk had wrongly been assessed as low). Most of these cases featured the following recurring themes.

[14] See HMICS, *Inspection of custody centre located in Aberdeen City Division* (2015) at paragraphs 16 and 17; *Inspection of Edinburgh Division* (2015) at paragraph 245; *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016) at paragraph 18; and *Inspection of custody centres located in Tayside Division* (2018) at paragraph 15.

27. In many cases the initial risk assessment was high, but the detainee was nevertheless put on 60-minute observations, the minimum available. We question the purpose of assessing a detainee as high risk if no action is subsequently taken to manage the risk posed. In one case, a detainee was assessed as high risk because he was beginning to show signs of heroin withdrawal while being booked in but was only monitored hourly. In another case, the detainee was intoxicated, aggressive and abusive towards staff, and refused to answer the vulnerability questions. Again, the custody record shows he was assessed as high risk and placed in a CCTV cell, but only hourly monitoring was recorded.

28. In other cases, detainees were assessed as high risk and placed on 30-minute observations which we did not deem sufficiently frequent due to the risks posed. This included one detainee who was suffering from drug withdrawal at the time of his detention. He had previously suffered seizures when experiencing drug withdrawal and should have been monitored more frequently.

29. In some cases where the initial risk assessment was low, the detainee was subject to constant, or 15 or 30-minute observations. This level of observations – particularly constant or 15-minute checks – suggested the detainee posed a significant risk that required careful management.

30. In several cases, we felt greater use could have been made of more frequent observations during the first few hours in custody, before reducing the checks as the detained person settled in or became less intoxicated. We saw this approach used in some cases, but it could have been used more often. In some of the cases about which we had concerns, we noted that initial decisions about risk and observation levels were not challenged or changed either by supervisors taking over on the next shift, or remote supervisors (in constable led-centres, the constable's decision making is remotely supervised by a sergeant at a another custody centre).

31. Despite the issues we have identified in some cases, it is also important to note that the risk assessment and subsequent care were exemplary in many cases and included custody staff re-assessing risk and adjusting care plans as needed.

32. In our report on custody centres in Tayside published in early 2018, we noted that while risk assessment is not an exact science, and much reliance is placed on the skill and experience of custody staff to interpret the information available to them, our recurring findings about the outcome and recording of risk assessments suggests that Police Scotland must do more to ensure effective vulnerability assessments and care plans in custody.[15]

Recommendation 5

Police Scotland should provide further guidance and training to staff on carrying out effective risk assessments and ensuring care plans manage the risks posed. Staff should also be reminded to record the rationale for risk assessments and care plans.

33. We understand that Police Scotland is developing a new approach to risk assessment and management which we welcome. This includes further changes to the vulnerability questionnaire which would afford the opportunity to include additional questions, such as asking a detainee whether it is their first time in custody, or about any physical or learning disabilities they may have. The service's approach to risk management is also under review with a new spectrum of observations being made available and more guidance on how observations should be carried out. This guidance could also include information on the circumstances in which different levels of observation should be used.

[15] HMICS, *Inspection of custody centres located in Tayside Division* (2018) at paragraph 19.

34. The new approach to observations will also include a change to Police Scotland's rousing policy. Currently, detainees are roused every 60 minutes, regardless of their level of risk. Rousing involves waking a detainee even if sleeping, and gaining a verbal response from them. We have previously expressed concern about the blanket application of the rousing policy, particularly for detainees who spend one or more days in custody. During our inspection, staff told us being woken hourly is one of the most common complaints from detainees. In 2014, we recommended that 'Police Scotland should review its hourly rousing policy and assess whether it is necessary and proportionate when applied to all detainees regardless of risk.'[16] This recommendation will remain open until Police Scotland implements its proposed new approach to rousing which we hope will be imminent.

35. To ensure its proposed risk assessment and management approaches are effective, Police Scotland should ensure their implementation is supported by guidance, training and quality assurance and audit arrangements, with feedback being given to custody staff where appropriate.

Constant observations

36. Constant observations of detainees may take place in different ways. Detainees may be observed via CCTV, via the window or glass door of the cell ('door closed' observations), or at the open door of the cell ('door open' observations). While we welcome new guidance from Police Scotland for officers and staff who are engaged in constant observations, we had some concerns that it was not always adhered to. For example, at one centre we visited, no one was monitoring the CCTV screen on which a detainee should have been constantly observed and, at another centre, we found magazines in an area only used for constant observations, suggesting staff may not be sufficiently focused on their task. Custody staff also told us about officers engaged in constant observations using their mobile phones.

37. Other concerns about the conduct of constant observations included:

- in a few cases we examined, CCTV observations were used when door open or door closed observations may have been more appropriate. For example, where a detainee poses a particularly high risk, CCTV is ineffective at monitoring the frequency and ease of their breathing
- where CCTV observations were being used, we were not confident in some cases that regular in-person checks of the detainees continued
- staff are sometimes required to monitor up to four detainees on a single split screen at once – Police Scotland should consider whether this is practicable for particularly high risk detainees.

38. We also had concerns about the conditions in which staff are required to carry out constant observations. Conditions were sometimes cramped and dark. For example, in Oban and Lochgilphead, observations were carried out of cells via a window into the room used for taking photos and fingerprints from other detainees. This would distract the observing officer but would also compromise the privacy of the detainee being observed. In another centre, solicitors were required to pass through the constant observations area to meet with their clients.

[16] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Recommendation 7.

39. There was also confusion in some centres about who should carry out constant observations. We have previously expressed concern about an over-reliance on local policing officers to carry out observations, even when custody staff are available to do so.[17] This has significant resource implications for local policing, as the officer is removed from his or her usual duties for the task. In some centres, PCSOs told us they were not allowed to carry out observations, hence the reliance on local officers. Police Scotland should ensure that local officers are not unnecessarily used to carry out constant observations.

40. Another way in which custody staff seek to safeguard detainees' safety is by removing their clothing and replacing it with special clothing which cannot be used to form a ligature. During our inspections of the 17 custody centres, we observed a variety of anti-ligature clothing and variable stock levels. The different types of anti-ligature clothing are linked to legacy force procurement arrangements but, five years after the creation of Police Scotland, we would have expected a consistent policy on which type of clothing is deemed the safest. The paper anti-ligature suits used in some centres are not appropriate for menstruating women, for example, but alternative clothing was not always available.

Searches

41. All detainees are searched upon entering police custody. More thorough searching, such as strip or intimate searches, is carried out according to risk. We found that strip searches were appropriately authorised and were consistently carried out by staff of the same gender as the detainee. We were concerned, however, that there did not appear to be a consistent approach to the strip searching of young people – some staff told us that an appropriate adult such as a parent or guardian would always be present, while others said this was never done. We consider the presence of a parent, guardian or other appropriate adult to be an important safeguard for all children under 16 in police custody, as well as for those aged 16 and 17 unless the young person prefers that the adult not be present. This would be similar to the current approach in England and Wales under Police and Criminal Evidence Act 1984 Code C.

Recommendation 6

Police Scotland should ensure there are appropriate safeguards in place when strip searching children under the age of 16, and 16 and 17-year-olds, in police custody.

Use of force

42. Police Scotland has a standard operating procedure on the use of force which requires it only to be used when it is necessary to achieve a lawful objective.[18] The use of force must be the minimum amount required and proportionate. We observed an appropriate and proportionate use of force being used on arrival at custody centres, during the booking in process and when detainees were moving around the custody centre. In our analysis of custody records, there were few examples of force being recorded and a spit hood was used in only one case.

[17] HMICS, *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016) at paragraph 21.
[18] Police Scotland, *Use of Force Standard Operating Procedure* (2016). This defines use of force as any physical use of force, except non-resistant handcuffing and 'come along hold' and includes empty-hand techniques, batons, irritant sprays (including draws), leg restraints, spit hoods and Personal Protective Equipment shields.

43. In 2014, we recommended that Police Scotland review its approach to the use of force in custody and focus on raising awareness, providing clear guidance and monitoring the use of restraint and force to inform policy and training. Despite this recommendation, there remain inconsistencies in how staff record use of force. Some staff told us they record any use of force in their notebook and by completing an electronic 'Use of Force' form on Scope (Police Scotland's human resources ICT system). These forms are reviewed by the National Operational Safety Training Unit (NOSTU). However, other staff told us that some use of force, such as the use of spit hoods, would be recorded on the custody record only. This discrepancy may have arisen because the Use of Force SOP requires recording in notebooks and on Scope, while the custody policy requires recording on the custody record. As a result, any data gathered on use of force by the NOSTU will be incomplete. This prevents the service from conducting an effective analysis of the use of force and to assess, for example, whether force is used disproportionately in some centres compared to others, or against detainees with particular characteristics. Furthermore, unlike forces in England and Wales, Police Scotland does not publish its use of force data, which would allow for greater transparency and analysis by stakeholders.

Recommendation 7

Police Scotland should publish force-wide data on the use of force.

44. Despite concerns about data quality, Police Scotland has nonetheless recently begun to analyse data on use of force which we welcome. Data is now being reported to a Use of Force Monitoring Group, chaired by an Assistant Chief Constable. This data relates to use of force across the service and not only in custody centres, although it has already been identified that the vast majority of spit hood use takes place within the custody environment. Currently, Police Scotland is able to assess whether force is being proportionately used across the North, East and West command areas,[19] but not yet at any more local level such as by custody centre. NOSTU is currently developing a new Use of Force form which it hopes will facilitate additional analysis, including by specific locations and protected characteristics. The introduction of this form will be supported by briefings to staff to encourage accurate recording.

45. All police officers and police staff working in custody centres must undergo operational safety training annually. This course covers the use of force. We previously reported in 2015[20] that PCSOs believe that much of the training is not relevant to working in the custody environment and that shorter or bespoke training would be a more efficient use of their time. The situation has not yet changed and we urge Police Scotland to reconsider the safety training for PCSOs. We do welcome, however, additional guidance developed in April 2018 by NOSTU for all new and existing custody officers and staff on safety in the custody environment.

Respect

46. In the custody centres we inspected, we found good awareness among staff of how to care for the diverse needs of detainees. However, there was a general lack of facilities for disabled detainees or those with a mobility difficulty. In one centre that was otherwise of a very good standard, we observed via CCTV an older detainee struggle to lower himself onto the low bed plinth and then to get up again. Occasionally, we visited centres with accessible toilets, higher bed plinths and more accessible call bells, but this was rare. We heard that staff seek to release detainees with additional support needs as soon as possible, or divert them to another centre that is better able to meet their needs. However, there is no centrally held log of centres with adapted facilities which could help ensure detainees are directed to the most appropriate centre.

[19] Force is used to a disproportionately greater extent in the West than in the North or East, but further work is needed to establish whether this relates to a greater use of force or greater recording of the use of force.
[20] HMICS, *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016) at paragraph 44.

47. Most centres we inspected catered for detainees' religious needs with various religious texts and prayer mats being available. In some centres, the direction of Mecca is marked on cell walls, and a holding room or dry cell is available for detainees to pray. In a small number of centres, more respectful storage arrangements for the Qur'an are required and staff should consider engaging with local faith groups to ensure the Qur'an and other religious texts are available where needed.

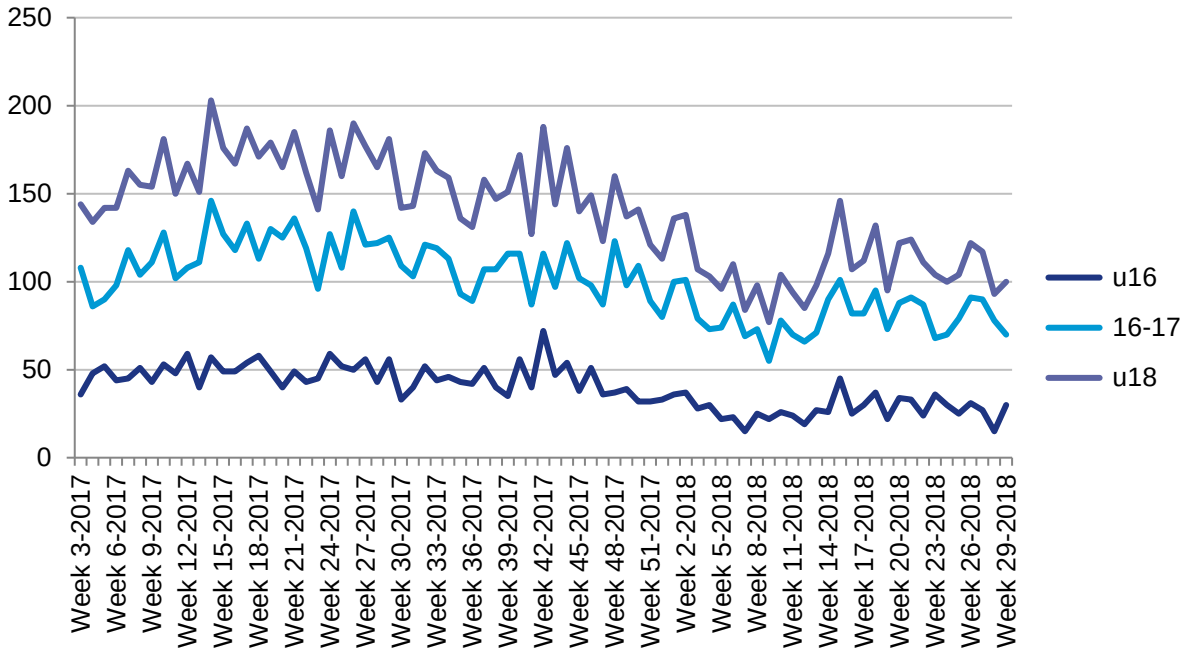
48. There was good awareness among staff of how to meet the needs of transgender detainees. They were aware, for example, that the custody policy states that detainees should be searched in accordance with the gender they present and live their lives as, which can be ascertained by asking detainees. We heard of a situation in which staff were reluctant to strip search a detainee whose appearance was that of a different gender from their gender identity. Police Scotland should consider providing guidance on the approach to be taken in such circumstances. We are aware that Police Scotland had invited the Scottish Trans Alliance to deliver training for custody staff working in one area, which we welcome and which would be useful to staff working across Scotland.

Children

49. When making decisions about whether to arrest, interview or charge a child under 18 or to hold them in police custody, section 51 of the Criminal Justice (Scotland) Act 2016 places a new duty on the police to treat the need to safeguard and promote the wellbeing of the child as a primary consideration. In recent years, the number of children coming into custody has fallen (see chart 1) and, at custody centres across Scotland, staff told us that significant effort was made to minimise as much as possible the amount of time spent in custody by children. Often, children are not lodged in a cell but are kept in an interview room and are generally accompanied at all times by police officers and a parent, guardian or other appropriate adult.

50. During our inspection, we heard about difficulties experienced by the police when seeking places of safety or secure accommodation placements for young people, rather than holding them in police custody. This is an issue we will follow up on during our strategic inspection of custody later in 2018-19.

Chart 1 – Children and young people in police custody[21]



[21] Prior to the rollout of the National Custody System in Week 3 of 2017, data on the number of children in police custody was manually collated by Police Scotland.

Women

51. Staff in many centres make considerable efforts to ensure the need of women in police custody are met. In some remote and island areas, this included recalling female officers to duty to ensure that female detainees were searched only by staff of the same gender. However, we have previously reported on inconsistent approaches to caring for women in police custody and, despite previous recommendations, it is clear these inconsistencies persist. In some centres, there is scope to improve the level of care provided to women and our previous recommendations relating to gender-sensitive care remain open.[22]

52. The custody policy states that male and female detainees should be kept, wherever possible, in separate areas within the cell accommodation. Many centres are set up for this with separate corridors designated as accommodation for women. However, even where these exist, they are not always being used. Some staff were unaware of the custody policy and instead cite a policy of non-gender specific care, introduced by Police Scotland in 2015. This policy allowed male staff to perform some duties in relation to female detainees. While this is acceptable in some circumstances (e.g. a routine check, where the cell door is knocked first to check the detainee is appropriately dressed and not using the toilet), some male staff felt uncomfortable carrying out these duties, particularly in centres without CCTV where any allegations could not be easily verified or disproved.

53. There were also inconsistent approaches to the constant observations of female detainees. Staff in some centres sought to adhere wherever possible to the custody policy that staff observing must be of the same gender as the detainee being observed. However, other staff did not follow this policy.

54. Across the centres we inspected, we noted a lack of female custody staff which we believe affected the quality of care offered to some women. For example, some women may not be able to shower if no female staff are present to monitor them. Since the introduction of the National Custody System in 2017, Police Scotland has been able to more easily gather data about its detainee population, including the number of women in custody. This information should be used to better plan its custody service, including decisions about resourcing.

55. The issue of sanitary protection for menstruating women in custody has recently been the subject of much media and political interest following a campaign by the Independent Custody Visiting Association in England and Wales. We support the objective of that campaign, which is to ensure that the dignity of menstruating women in police custody is maintained. This can be achieved by providing a varied and adequate supply of sanitary protection, changes of underwear or clothing, access to handwashing facilities and more frequent showers. Again, we found inconsistency in provision across the custody centres we inspected. Some centres offer only sanitary towels, while others offer towels and tampons. Some centres had a good stock of alternate clothing, but few had underwear although staff told us that this would be bought locally if friends or family were not able to bring it to the centre. Few centres have in-cell handwashing facilities meaning most detainees have to use their call bells to ask to use the communal sink. Three of the 17 centres we inspected had no shower, begging the question of whether they are even suitable for holding menstruating women. Due to the absence of female custody staff at many centres, female detainees will often have to ask male staff for assistance which they may be reluctant to do.

[22] HMICS, *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016), Recommendations 2 and 3, and for a fuller discussion of gender-sensitive care, see paragraphs 31-33.

Custody environment

56. While the custody centres are generally secure environments, some are used by non-custody personnel as a means of accessing other parts of the police station. This should be avoided wherever possible, however this is difficult in a few centres due to the layout of the building. The need to maintain a secure custody environment should be considered in any capital investment in the custody estate. The layout of the custody centre at Greenock was of particular concern. Detainees are required to pass through the narrow area behind the booking in desk to reach other parts of the custody centre, such as the room housing the intoximeter. This is not appropriate and requires careful management by staff escorting them.

57. Most centres have CCTV in communal areas or in some, if not all, cells. We were surprised that there remain some centres with no or very limited CCTV coverage. This can be a useful tool in managing the custody centre and detainees safely. CCTV was being installed for the first time at the custody centre in Greenock at the time of our inspection. Earlier in 2018, we recommended that Police Scotland should ensure that the toilet areas of cells monitored by CCTV are pixelated to preserve detainee privacy.[23] This is the usual practice in most custody centres, but continues to be absent in others and our recommendation remains open.

58. Repairs are often required within custody centres and these are carried out by a private sector company under a general maintenance contract with Police Scotland. However, we heard concerns about the quality and speed of repairs, particularly in rural and island locations. Police Scotland is aware of these issues and is engaging with the contractor to address them.

59. The cleanliness of the custody centres we visited was variable. While many were well looked after by cleaning and custody staff, some required a deep clean and some required more thorough day-to-day cleaning. Centres in which PCSOs regularly carried out cleaning duties tended to be of a higher standard, and their pride in their workplace was clear. In some legacy force areas however, cleaning does not form part of the PCSO job description. This can be problematic for centres where cleaners are only employed Monday to Friday. While some PCSOs will carry out cleaning duties at the weekend when required, in one centre, we heard that cells, mattresses and pillows would occasionally be reused between detainees. This is not acceptable and carries hygiene risks. While some custody centres are old and keeping them well maintained and clean can be challenge, it is worth noting that some older centres, such as Dunfermline, are nonetheless maintained to a high standard by custody staff.[24]

60. Weekly checks of custody centres are carried out by custody staff. These checks include identifying any potential ligature points within the custody environment and any other matters which may compromise the safety or wellbeing of detainees and staff. While we welcome these regular checks, we are concerned that despite them, we continue to identify issues during our own inspections, such as a lack of cleanliness. We query what guidance is being given to staff carrying out the checks, and what systems are in place to address or escalate any issues identified. In particular, we suggest that staff carrying out checks are given guidance on identifying and managing ligature points. While it may not be possible to remove all potential ligature points, all staff working in a custody centre should be aware they exist and how any risks are to be managed.

[23] HMICS, *Inspection of custody centres located in Tayside Division* (2018), Recommendation 1. This recommendation followed an earlier improvement action, made in 2014, to make the necessary adjustments to CCTV where, for example, pixelation is absent.

[24] For previous HMICS commentary on the cleanliness of custody centres, see *Inspection of custody centres located in Tayside Division* (2018) from paragraph 23.

Detainee care

61. We found those working in custody to be professional and respectful, and the detainees we spoke to said they had been treated fairly. The quality of care was particularly high in some rural and island centres where local policing staff were conscious that those who were detained were members of their local community, and their focus was on building a positive relationship with them whilst in custody. More generally, we tended not to see any significant engagement between detainees and staff outside of required interactions (such as hourly visits) despite this being an effective way of managing risk and supporting vulnerable people in custody.

62. In several centres inspected, a request culture persisted with detainees only able to access certain entitlements if they ask for them. This relies on the detainees being both aware of their entitlements and willing to ask. This included aspects of care such as handwashing and showering facilities, exercise and fresh air, and reading materials. In some centres, the request culture is partly dictated by the custody centre itself – detainees are required to ask for things that would not be necessary elsewhere. For example, in some centres, the toilet flush for each cell is located outside the cell, meaning detainees have to use their call bell to summon staff and ask them to flush the toilet on their behalf. Similarly, only a small number of centres have cells with integral handwashing facilities meaning that if detainees wish to wash their hands after using the toilet or before eating, they have to ask staff to take them to a communal sink (such requests are rarely made, compromising hygiene for both detainees and staff). These estate issues result in additional pressures on staff, and can result in delays for detainees at busier times. We also observed variations in approaches to providing toilet paper – some centres require detainees to ask for any toilet paper, while others provide it routinely unless a risk assessment dictates otherwise.

Food and drink

63. Centres generally offer a range of food to detainees and will do so whenever required, taking into account when an individual detainee last ate. The food available typically includes ambient meals (although the range appears to have been reduced since our last inspection), Pot Noodles, porridge and cereal bars. Detainees are generally critical about the quality of the ambient meals and we welcome the introduction of the more popular Pot Noodles. However, not all staff appeared aware of the risks the plastic pot could pose. Some staff were alert to such risks and either decanted the Pot Noodles into a cardboard cup, or ensured they were quickly removed from a detainee's cell after being eaten. All staff were aware of the need to cater for various diets and allergies, and would obtain appropriate food from local shops if necessary. Some local health care professionals expressed concerns about the nutritional value of the food offered, which we shared, particularly for those detainees in custody for several days. However, staff generally were willing to provide additional food where requested.

64. We had two main concerns about the provision of food and drink at custody centres. Firstly, some police officers were working in custody and regularly preparing and serving food without the necessary food hygiene training. Secondly, the food and drink in some centres, particularly those with a lower throughput of detainees, was out of date. In these centres, there was a need for improved stock control.

Showers and exercise

65. In our previous inspections, we have often noted limited opportunities for detainees to shower and exercise while in police custody and, in 2014, we recommended that Police Scotland should review the availability of showers and exercise. We continue to find a variable approach across the custody centres inspected.

66. At three of the 17 centres we inspected, there was no shower and detainees are only able to wash at sinks on the cell corridor with limited privacy. All other centres had at least one shower, although the extent to which it was used varied. In some centres, it appears common practice to offer detainees the opportunity to wash at a sink, rather than shower. While some detainees may favour this option, it may not be suitable for all. In other centres, the offer of a shower appears routine. Staff told us that opportunities to wash or shower can be limited by the availability of staff. The layout of some centres can also limit the privacy afforded to detainees when washing, and the positioning of swing doors for privacy over shower cubicles in some centres is at an inappropriate height for women.

67. Only three of the 17 centres we inspected had exercise yards. While two of the exercise yards were routinely used to allow detainees fresh air, the third yard was never used. At centres without exercise yards, opportunities to briefly take some fresh air in the police station's secure yard were sometimes offered to detainees where it was thought this would be beneficial, such as for compliant detainees who had been in custody for several days, or those who required a cigarette and did not have access to nicotine replacement therapy.

Clothing, bedding and other supplies

68. Police Scotland has introduced improved processes for ordering and managing stock within custody centres which appear to work well in some areas but not others. We continue to find some centres which are well stocked with alternative clothing and shoes for detainees, blankets, towels, toiletries and other supplies, while other centres are missing key items or have very low stock. In some rural and island centres, local staff were not aware that, for example, alternate clothing could be ordered via Police Scotland and were instead donating their own clothing or gathering items from charity shops.

69. There also appeared to be unnecessary variation between custody centres regarding which items would be provided to detainees. For example, some centres provide toothbrushes and razors, while others do not. This is despite the custody policy which states that where a person is detained for more than one day, they should have the opportunity to shave. There is also variation in the quality and sufficiency of bedding across the centres we inspected.

70. Most centres we inspected had some books or magazines available for detainees although the quality of some was poor and we saw few examples of foreign language materials. The quality and variety of reading materials was dependent on the efforts of local staff.

Lighting

71. Across the centres we inspected, there was an inconsistent approach to whether the light in cells would be dimmed or switched off at night. This was sometimes dictated by local facilities (some centres have no dimmer function) but also by local culture and practice. Some staff told us they would dim or switch off lights only when requested by the detainee, while others said that they routinely dimmed lights at night to help detainees sleep unless a risk assessment dictated otherwise.

Release and transfer from custody

72. Prior to being released from police custody, detainees undergo a risk assessment to ensure they do not pose a danger to themselves or others. This was routinely carried out in the records we analysed and we observed some good examples of custody staff seeking to ensure appropriate support was in place upon release. This pre-release risk assessment has been introduced since our last thematic inspection in 2014 and addresses our suggestion that Police Scotland consider a more formalised pre-release process to assure, as far as possible, detainee safety post-custody.[25] We noted variation in how the pre-release risk assessments were carried out across the centres we visited – some staff treated it as a formal process to be carried out at the booking in desk and recorded on CCTV, while others would ask detainees the relevant questions in their cell while doing other tasks such as making an hourly visit or delivering breakfast.

73. Where detainees are released from custody to appear at court, they are escorted by a private contractor (G4S). A Person Escort Record (PER) is completed by custody staff and given to G4S as a means of sharing known risks that a detainee poses to themselves or others. Since we recommended in 2015 that PERs be completed with all known risk factors, their quality has improved significantly.[26] However, in our analysis of custody records, we found that some PERs still lacked key information. The missing information often related to the detainee's time in police custody and we suspected that PERs were being completed shortly after the detainee was booked in, but not updated prior to release. For example, if a detainee saw a health care professional and received medication while in custody, this was sometimes not included in the PER form contrary to the custody policy.

74. We observed the efficient handover of detainees to G4S at several centres. In one case at Hawick, we observed good discussions between custody staff and G4S about how best to manage a detainee with significant vulnerabilities. This helped ensure his safe transfer to court.

Transfers between custody centres

75. Once booked into a custody centre, a detainee may be transferred to another centre for a variety of reasons. Most often, this is likely to be because the centre or cluster of centres in which he is first detained is at or near capacity. This happens during weekends when centres are busier, and typically happens in certain areas where there is insufficient capacity to meet local demand, such as in Edinburgh and Lothians and Scottish Borders Divisions. Detainees may also be transferred to another centre when that centre has facilities or resources that are better able to meet their needs. For example, a detainee who requires constant observations at a centre without the facilities or resources to facilitate this will be transferred to a more appropriate centre. These transfers can happen at any point during the week.

76. In 2014, we noted the frequency of custody transfers and the distances travelled in some cases, and asked Police Scotland to improve its guidance for conducting transfers.[27] Police Scotland now has Custody Transfer Guidance which sets out the circumstances in which detainees may be transferred, how transfers are to be governed, the criteria for determining which detainees are suitable for transfer, and the responsibilities of the dispatching and receiving centres.

[25] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Improvement Action 10.
[26] HMICS, *Inspection of Edinburgh Division* (2015), Recommendation 5.
[27] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Recommendation 3 and from paragraph 23.

77. While we welcome this guidance, we continue to hear concerns from custody staff that some detainees are inappropriately selected for transfer. The guidance states that, ideally, transferring detainees will be low risk and without complex medical needs. It also urges caution where detainees have previously been subject to constant observations but have since been reduced to a less frequent visiting regime. One of the centres we visited during our inspection was Greenock, which often receives transferred detainees because it has a large number of cells but a low throughput. We analysed a random selection of custody records of 20 people detained at Greenock, five of which related to transferred detainees. They had been transferred from three custody centres in Glasgow. We had concerns about whether it had been appropriate to transfer two of these detainees. In one case, while the detainee had been assessed as low risk when being booked into custody, he later behaved erratically and sought to harm himself. He was restrained and put under constant observation and later taken to hospital after complaining of abdominal pain. Upon return from hospital, where he had received morphine for his pain, he was removed from constant observation and later transferred to Greenock. Given his history in detention, we were concerned that it was deemed appropriate for him to be transferred not for his own welfare, but to free up capacity in Glasgow. In each of the custody records of the transferred detainees, there was scope for improved recording of the reasons for their transfer, and why they had been assessed as most suitable for transfer compared to other detainees held at the same centre.

78. Data on the reason for transfer is not easily gathered by Police Scotland and there are questions about transfer data quality.[28] Data provided from Police Scotland suggests that between January 2017 and July 2018, the number of transfers ranged from 36 to 125 per week. While there are significant fluctuations in the number of transfers that take place each week, the overall trend has been a reduction in the volume of transfers between 2017 and 2018. Nevertheless, there are still a large number of detainees being transferred each week. This highlights the challenges faced by Police Scotland in matching demand with the available custody estate and resources. Pending any longer term estate solutions or reductions in throughput, Police Scotland must manage the risks associated with transferring detainees as effectively as possible.

Legal rights

79. The Criminal Justice (Scotland) Act 2016 made significant changes to arrest and detention procedures. The Act came into force on 25 January 2018, a few months before our inspection, and we took the opportunity to consider early experience of its implementation.

80. We found that the requirements of the Act were being met. All officers and staff were aware of its provisions and had received training. For some, this training had taken place a considerable period before the Act came into force due to repeated delays in its implementation. This meant they had to re-brief themselves on its requirements closer to the date of implementation. Custody staff, and those officers who worked in custody regularly, were more confident in their knowledge of the Act, but some local policing officers, including those who provided cover in custody less frequently, were less confident and relied on colleagues and written guidance.

[28] For example, some detainees included in the data have not actually been transferred but have been 'administratively' moved from one centre to another because they were initially booked into the wrong centre on the National Custody System. An internal audit of 1,600 transfer records found an error rate of 6% (i.e. 6% more detainees were recorded as being transferred than actually were). This error rate has been factored into the data presented in this report.

81. Where a person has been arrested but not yet officially accused of an offence, the Act requires his detention to be authorised by a sergeant or higher ranking officer not connected with the investigation only if the test set out in section 14 of the Act has been met. This test requires that there are reasonable grounds for suspecting the person has committed an offence, and that keeping the person in custody is necessary and proportionate. If not charged with an offence, the suspect may only be held for 12 hours, unless an inspector or higher ranking officer not involved in the investigation deems that the section 14 test continues to be met, that the offence is serious, and that the investigation is being conducted diligently and expeditiously. Detention may only be extended by another 12 hours. After six hours (and after 18 hours), a custody review is carried out by an inspector to check that the grounds for detention still exist.[29]

82. In our review of custody records, we found that appropriate grounds for detention existed in all cases. We also found that custody reviews and authorisations to extend detention beyond the 12-hour limit were carried out as necessary, and that there was good recording of the reasons for the person's continued detention.

83. We did not examine any records or observe any cases where authorisation for the initial detention was not given. During our inspections of the custody centres, we heard from custody supervisors in some areas that they regularly received calls from frontline officers to check whether detention was appropriate in the circumstances of the incident they were dealing with. Where the supervisor advised them it was not appropriate, the officers would not bring the person to the police station. As a result, accurate data cannot be drawn from the National Custody System regarding the number of refused authorisations for keeping a person in custody.

84. In ancillary centres operated by local policing officers and in custody centres which are led by a constable, remote authorisation for detention must be sought from a sergeant at another custody centre.[30] Officers seeking authorisation told us that they sometimes struggled to make contact with a sergeant and had to wait until the sergeant was available, or call round other custody centres until they found one. This causes unnecessary delays in the processing of a detainee. We have been assured by Police Scotland that systems are being put in place to address this.

[29] The provisions outlined in this paragraph relate to adults in custody. Additional safeguards exist for children and young people including, for example, that their detention is authorised by an officer of a higher rank.
[30] Local policing sergeants are often not able to authorise detention because they have had some prior connection to the investigation.

Legal assistance and information

85. All those held in police custody have the right to have intimation of their detention sent to a solicitor, and to have a private consultation with their solicitor at any time. Detainees who are going to be interviewed by the police also have the right to have a solicitor present during the interview. Detainees are informed of these rights, and their right to waive them,[31] by custody staff. Since the implementation of the 2016 Act, this is done by staff reading out the Police Interview – Rights of Suspects (PIROS) form. This replaced the Solicitor Access Recording Form about which we had expressed concerns in 2014.[32] The PIROS procedure improves on what existed before but can still be confusing, particularly for some detainees such as those with learning difficulties. The procedure involves informing detainees of their rights by rote, regardless of whether some rights have already been exercised and, for example, the detainee's solicitor is already present at the police station. The form requires officers to check that detainees have understood each of their rights, but there is little guidance as to what should happen if detainees say they do not.[33]

86. Despite being informed of their legal rights, many detainees choose to waive them. While detainees often ask for a solicitor to be notified of their detention, fewer detainees request a telephone consultation with a solicitor, and fewer still benefit from a solicitor's attendance at the police station. In some centres we inspected, we heard that telephone consultations can be hampered by the poor sound quality of the telephone line and a few centres lacked an appropriate solicitor consultation room. This is despite significant investment by Police Scotland in its custody estate in preparation for the implementation of the 2016 Act. We also heard from staff that there can be delays in solicitors attending the centre which can prolong a person's time in custody. Our findings echo some of those published in a recent report by Justice Scotland.[34] It makes 17 recommendations directed towards the Scottish Government and other criminal justice organisations, including Police Scotland, so that a suspect's right to legal assistance, as well as being established in law, remains effective in practice.

87. During our inspection, we found that the Letter of Rights (a booklet setting out rights of people in custody) was routinely given to detainees, although was refused by the detainee in a small number of cases. While custody staff were aware that the Letter of Rights was available in a range of languages, there was little awareness of the existence of an 'easy read' version. In one case involving a vulnerable detainee with communication difficulties, we noted that the easy read version was not provided even though it may have been more suitable (subject to our comments at paragraph 88). The appropriate adult supporting the detainee also failed to ask custody staff to provide the easy read version.

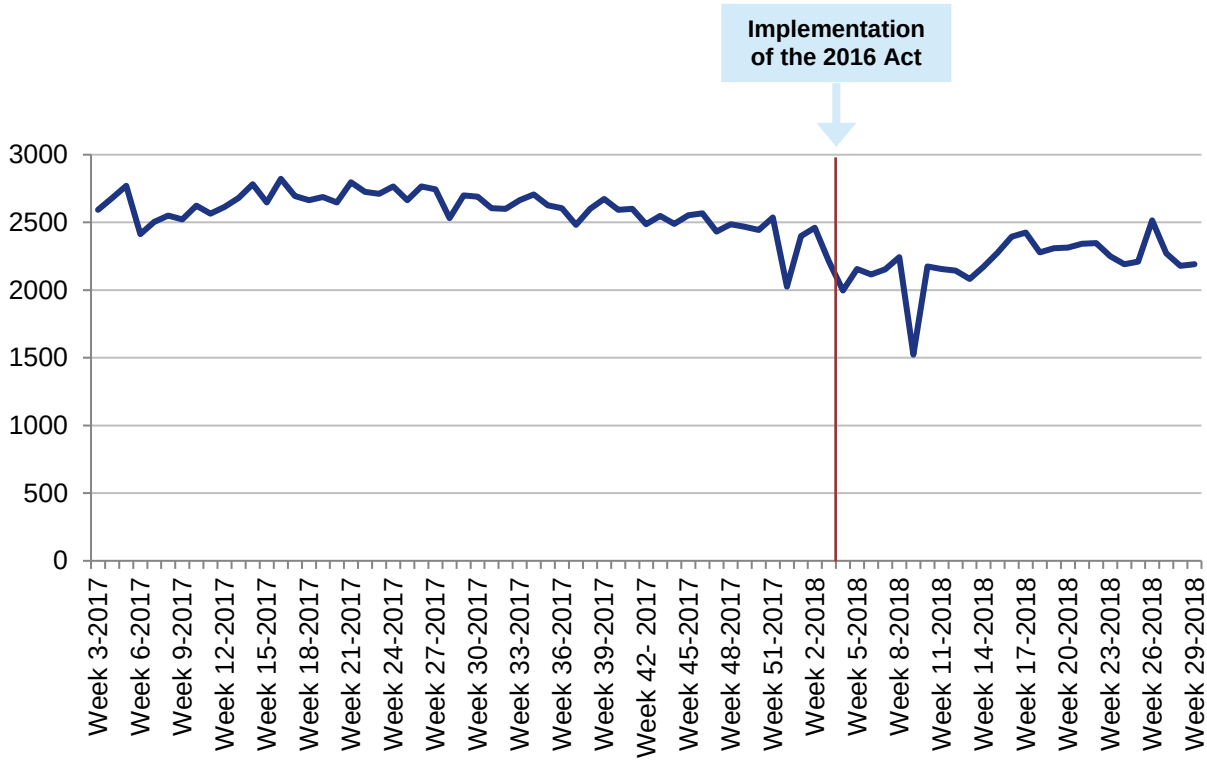
88. While an easy read Letter of Rights is available, we agree with comments made in the recent report by Justice Scotland that it is not entirely clear what makes this version easier to read than the standard version.[35] There is a genuine need for an easier to read Letter of Rights, and we would encourage the Scottish Government to work with relevant experts to ensure one is made available.

[31] Some detainees are not able to waive these rights, such as those under 16, or are able to do so only in certain circumstances – see section 33 of the 2016 Act.
[32] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Recommendation 9 and from paragraph 76.
[33] A fuller discussion of the PIROS form can be found in Justice Scotland, *Legal assistance in the police station* (2018) at paragraphs 2.5-2.6 and from 3.30.
[34] Justice Scotland, *Legal assistance in the police station* (2018).
[35] Justice Scotland, *Legal assistance in the police station* (2018) at paragraph 3.21.

Impact of 2016 Act

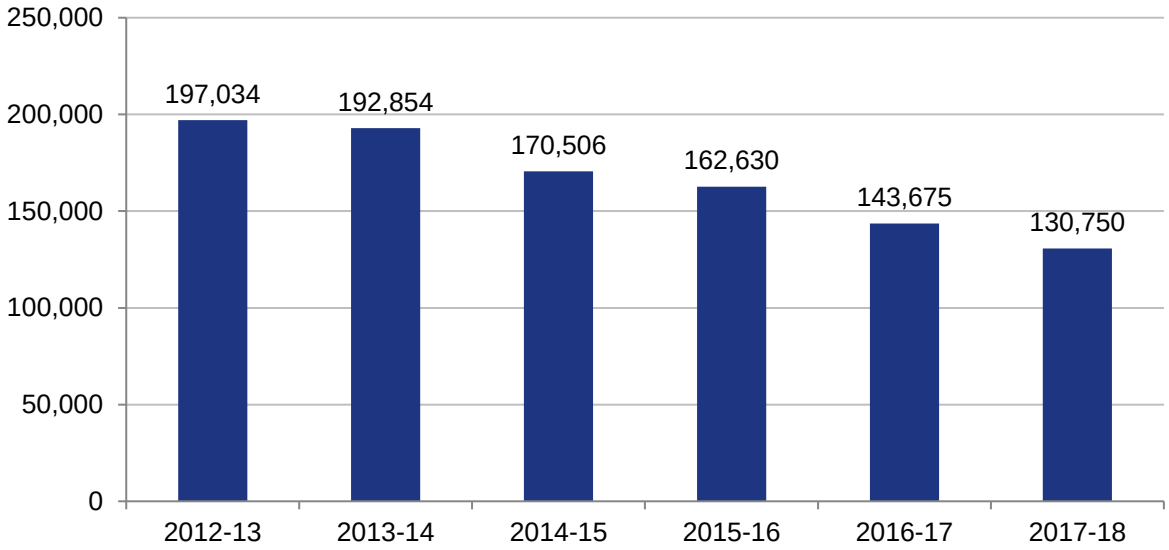
89. It had been widely anticipated that the implementation of the 2016 Act would result in a reduction in the number of detainees in custody and/or in the length of time they spend in custody. This would be in keeping with the ethos of the Act, that people are detained only when it is necessary and proportionate. While there has been a reduction in custody throughput between 2017 and 2018 (see Chart 2), it is not possible to wholly attribute this to the implementation of the Act itself. This is because throughput has been declining for the last several years: it fell from 197,034 in 2012-13 to 130,750 in 2017-18 (see Chart 3).

Chart 2 – Weekly throughput 2017-2018[36]



[36] Weekly throughput is shown from Week 3 of 2017, when the National Custody System was rolled out, until Week 29 of 2018. The drop in throughput seen around week 9 of 2018 correlates to extremely poor weather conditions.

Chart 3 – Annual custody throughput 2012-2018



90. In relation to average time spent in custody pre and post-implementation of the 2016 Act, there appears to be little difference. The average duration of detention episodes was 15.9 hours in 2017 and 15.1 hours in 2018. In the 145 custody records we examined (drawn from April 2018), the shortest time a person spent in custody was 13 minutes, the longest was almost 86 hours and the average was 15.9 hours. In our sample:

- 39% of detainees were released within six hours of their arrest
- 23% were released between six and 12 hours
- 19% were released between 12 and 24 hours
- 5% were released between 24 and 48 hours
- 12% were released between 48 and 72 hours
- 1% were released after 72 hours.

91. The 2016 Act introduced new powers for the police to release a suspect from custody pending further investigation ('investigative liberation'), and to re-arrest a suspect for the same offence. Between 25 January and 30 June 2018, investigative liberation was used on 257 occasions. This is significantly less than the 3,240 per year estimated at the time the Criminal Justice (Scotland) Bill was introduced.[37] Officers told us the ability to use investigative liberation and re-arrest suspects were useful tools, while custody staff said they felt the Act had encouraged investigating officers to expedite their enquiries.

[37] Scottish Parliament, *Criminal Justice (Scotland) Bill: Explanatory Notes (and other accompanying documents)* (2013), at paragraph 59 of the Financial Memorandum.

Appropriate adults

92. Appropriate adults should be called to help facilitate communication between the police and detainees with a mental disorder or learning disability. Appropriate adult schemes exist in all areas but vary in nature. Some are provided by local authority social work departments, while others are provided by voluntary or private sector organisations. Appropriate adults were used for 3% of the custody records we reviewed, although there were a few additional records where the information suggested an appropriate adult may have been beneficial.

93. We heard mixed views from custody staff about the quality and timeliness of the appropriate adult service in their area. Some said the service was good at any time, while some said they had difficulty securing the attendance of an appropriate adult out of hours. There appeared to be some correlation between poorer quality and timeliness and a social work-provided service. This may be linked to the many other demands placed on social work services and the fact there is currently no statutory duty on local authorities to provide an appropriate adult service. We welcome a recent Scottish Government consultation on introducing such a duty.[38]

94. In one case we observed, we noted that an appropriate adult attended but contributed little to helping the detainee understand the legal processes taking place at the custody centre. This, coupled with other anecdotal evidence we heard from custody staff, suggests there is a need for some appropriate adults to have a greater awareness of their role, and improved training in supporting vulnerable people.

95. Several custody staff told us they would welcome training on identifying people with learning difficulties so that they would be more confident in securing the assistance of an appropriate adult when needed.

Independent custody visitors

96. Independent custody visitors are volunteers from the local community who check on the treatment of and conditions for detainees in police custody. The custody visiting scheme is managed by the SPA and their role is set out in Chapter 16 of the Police and Fire Reform (Scotland) Act 2012. As at 31 March 2017, there were 159 visitors across Scotland and they made 1,567 visits to police custody in 2016-17. During those visits, they spoke with 3,080 detainees.[39]

97. During our inspection, we met with custody visitors from across Scotland and discussed their experience of custody. A common theme in our discussions was the delays custody visitors experience in accessing custody centres. This issue has been highlighted in annual reports on custody visiting published by the SPA, yet the problem persists. Such delays are not in keeping with the spirit of the 2012 Act which states that independent custody visitors be able to access, without prior notice, any place in which a detainee is held. While delays in granting access to custody visitors may occur from time to time when custody staff are particularly busy and no one is available to let them into the custody centre, this should not be the norm. There is scope for Police Scotland to raise awareness among custody, front counter and service centre staff of the important role of independent custody visitors and to ensure they are granted access to the custody centre timeously.

98. We also heard that some custody staff, and some visitors themselves, are resistant to visitors looking at custody records because they contain the personal details of detainees. Alongside speaking to detainees, examining custody records can be a key source of information when assessing treatment and conditions within custody, and there is no basis for such resistance. Section 93(b) of the 2012 Act clearly states that independent custody visitors may be authorised to 'examine records relating to the detention of persons'. The code of practice on independent custody visiting in Scotland, the custody visitor handbook and associated training materials also state that visitors have access to custody records and should use them.

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[38] Scottish Government, *Establishing a statutory appropriate adult service in Scotland* (2018).
[39] SPA, *Independent Custody Visiting Scotland – Annual Review 2016/17* (2017).

Health care

99. Because of the complex health needs of many detainees, we consider the availability and quality of health care to be a key element in assessing their overall treatment while in police custody. However, as health care in police custody is delivered by the NHS, it is outwith the remit of HMICS (see paragraph 14). Nonetheless, we discussed health care arrangements with custody staff, spoke with doctors attending at custody centres and, in our review of custody records, checked that all detainees who required health care received it.

100. The way in which health care in police custody is delivered varies across custody centres according to local NHS arrangements and the type of centre and its throughput. Busier custody centres in some areas have nurses based permanently on-site, although no such arrangement was in place for any of the centres we visited during our inspection. A few of the centres we visited were covered by a nurse based at another custody centre nearby who was available for telephone advice and would attend if needed. Other centres relied on local doctors attending at the centre when required, or officers would escort detainees to the nearest hospital.

101. During our inspection, we heard both positive and negative comments about health care arrangements. There was much praise for custody-based nurses and many staff working in remote or island custody centres said local doctors attended at the centre as soon as practicable. However, staff in other centres expressed concerns about the availability and quality of health care. This was a particular concern in Elgin where officers are required to take detainees to hospital if medical assistance is required. This results in local policing officers being taken away from frontline duties, often for prolonged periods of time, and in custody staff using higher levels of observations than might usually be the case, because they are concerned detainees have not received an appropriate level of health care. As noted at paragraph 14, the current lack of scrutiny of health care in police custody limits opportunities to achieve better health outcomes for detainees.

102. Pressures on health services can impact on custody and local policing more generally. During our inspection of Greenock, we observed a medical emergency and a detainee waiting an hour before paramedics were able to attend and take him to hospital. Custody staff worked hard to reassure the detainee and to provide appropriate support. While waiting for the paramedics, the centre was closed to new detainees meaning that local policing officers were required to wait in unsuitable conditions with other detainees who needed to be booked in, or take them to another custody centre for processing. As noted above, officers can also spend long periods of time at hospital while waiting for detainees to be assessed. In several areas, Police Scotland has worked with its health partners to develop initiatives to help minimise time spent by officers at hospital, such as community triage services.[40]

103. All custody centres have first aid kits but there is less consistency in the provision of defibrillators. Some have defibrillators in the custody centre itself or the police station, but others do not. This is despite the findings of a Fatal Accident Inquiry published in 2017 in which the Sheriff recommended that consideration be given by Police Scotland and NHS Scotland to equipping all custody centres with defibrillators and training officers to ensure they are able to recognise a situation where defibrillators may be needed and to use them.[41]

[40] See, for example, the description of the Community Triage Service in Tayside in HMICS, *Local Policing+ Inspection Programme: Inspection of local policing in Tayside Division* (2017).
[41] Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the death of Kevin Michael McGurty [2017] FAI 1.

Referral and diversion schemes

104. Given the vulnerability of many people who come into contact with the police, we would expect there to be referral and diversion schemes in place that offer support for those experiencing mental health crisis or dealing with alcohol and drug addiction. In our thematic inspection in 2014, we noted that such arrangements varied widely and we recommended that Police Scotland work with its NHS, local authority and voluntary sector partners to address gaps in provision. In our current inspection, we found some evidence of the police referring detainees to organisations that could offer them support. However, this was even less extensive than we had seen in 2014 and previous arrangements whereby support workers would attend at custody centres to offer assistance to detainees appeared to have stopped in many areas. This is an issue to which we will return in the strategic phase of our custody inspection.

Strategic delivery of police custody

105. Following our assessment of the treatment of and conditions for detainees in 17 custody centres across Scotland, we intend to review the strategic delivery of police custody arrangements. This will include consideration of the broader HMICS inspection framework, including an assessment of leadership and governance, planning and process, people, resources and partnerships. During our inspections of the 17 centres, we were able to gather evidence to support this second inspection and which has helped identify specific issues on which we will focus. Some of these issues have been identified as ones that are working particularly well, while others may require improvement.

106. In relation to leadership and governance, for example, our inspection will consider Police Scotland's vision for the future delivery of police custody, including the introduction of Criminal Justice Hubs. It will also consider how management information is used to support the delivery of an effective custody service, and will assess the quality of governance arrangements for police custody, including internal scrutiny, quality assurance and audit. It will also consider communication within Criminal Justice Services Division and its relationship with local policing divisions.

107. In relation to resources, we will consider the extent to which Police Scotland is effectively managing its custody estate and ensuring the estate meets the needs of today's detainee population. We will also assess whether custody is sufficiently resourced, how resources are distributed across the country and how vacancies are managed.

108. Our inspection will take place later in 2018-19 and will involve speaking with a range of officers and staff within Criminal Justice Services Division and Police Scotland more widely, as well as stakeholder organisations. It will result in a published report and will include an assessment of the extent to which previous recommendations relating to leadership and governance, planning and process, people, resources and partnerships have been implemented.

Appendix 1 – Status of custody recommendations

Since Police Scotland was established in 2013, HMICS has published six police custody inspection reports. These reports included 27 recommendations and 47 improvement actions. The table below sets out whether the recommendations and improvement actions remain open or whether sufficient evidence has been received by HMICS to justify closure. Several recommendations were reviewed and closed prior to our current inspection. It should be noted that where a recommendation remains open, progress towards its implementation may well be underway.

Of the 27 recommendations, 12 have been closed and one is closed in part. Of the 47 improvement actions, 26 have been closed. In our forthcoming inspection of the strategic delivery of custody by Police Scotland, we anticipate reviewing and closing additional recommendations and actions.

Recommendation/Improvement action		Status	Date closed/commentary in this report
Thematic inspection of police custody arrangements in Scotland (2014)			
R1	Police Scotland should introduce more efficient processes to better manage capacity across the custody estate. These processes should allow officers to be effectively directed to custody centres where there is sufficient available capacity to accept their detainees.	Closed	January 2016. Custody capacity is proactively monitored and managed by the Divisional Coordination Unit, while the Force Custody Inspector (FCI) manages capacity in real time. Created in October 2014, the FCI is available 24/7.
R2	Police Scotland should review its approach to single cell occupancy and consider a more proportionate approach to risk assessment allowing local discretion to use multiple cell occupancy where appropriate.	Closed	August 2018. Police Scotland has reviewed its approach to single cell occupancy. The custody policy now states that only one detainee will be placed in a cell and that multiple occupancy of a cell should only be considered when all other options have been exhausted, and only after transferring detainees to another centre and reviewing existing disposal decisions have been considered.
R3	Police Scotland should reassess the future level of demand and need for detainee transfers alongside the wider management of capacity across the custody estate in order to develop a more sustainable model. The current transfer protocol should be reviewed and incorporated within custody policy.	Partially open	The first part of this recommendation remains open. It is closely linked to the development of a custody estate strategy (R14) and modelling based on predicted future throughput (paragraph 89). Police Scotland had anticipated that throughput would drop sufficiently after the implementation of the 2016 Act so as to negate the need for transfers. This has not yet happened (paragraph 78). As at August 2018, the second part of this recommendation, relating to a custody transfer protocol, is closed (from paragraph 75).
R4	Police Scotland should review the wider security of the custody environment and conduct a physical security audit at each custody centre.	Closed	September 2015. Police Scotland carried out security audits of all custody centres by January 2015.

R5	Police Scotland should undertake routine health and safety inspections within custody centres, including a wider review of equipment standards and availability, staff awareness of accident and fire records, and fire evacuation procedures and drills.	Closed	August 2018. Health and safety inspections of all primary custody centres were carried out by 2015, and an on-going programme of health and safety activity is being overseen by the divisional Health and Safety Committee. The Committee is chaired by a divisional superintendent and meets every two months.
R6	Police Scotland should review its approach to use of force in custody and focus on raising awareness, providing clear guidance and monitoring the use of restraint and force at a divisional level in order to inform policy and training.	Open	From paragraph 42.
R7	Police Scotland should review its hourly rousing policy and whether it is necessary and proportionate when applied to all detainees regardless of risk.	Open	Paragraph 34.
R8	Police Scotland should review the availability of showers and exercise for detainees to develop a consistent approach and reflect this within any future estate improvement programme.	Open	From paragraph 65.
R9	Police Scotland should engage with criminal justice partners and review the solicitor access recording form to improve accessibility. Police Scotland should ensure officer guidance and training emphasises the need to communicate the form's contents in a manner that is better understood. Police Scotland should also ensure that the Letter of Rights is issued when required during the booking-in process and this is verified in the custody audit process.	Closed	January 2018. Police Scotland provided additional guidance to staff on delivering the solicitor access recording form (SARF) and ensuring Letters of Rights are issued. The SARF has been replaced with the PIROS form (paragraph 85).
R10	Police Scotland should join with its partners in the NHS, voluntary sector and local authority social care, recognising the role of community planning partnerships and alcohol and drugs partnerships across Scotland, to review the scope of current referral and diversion schemes and seek to address any gaps in provision.	Open	Paragraphs 12 and 104.
R11	Police Scotland should secure more robust management and performance information and develop a stronger evidence base to enable the evaluation of benefits and outcomes for the division.	Open	Since the introduction of the National Custody System across Scotland in January 2017, Police Scotland is now in a better position to gather management and performance information. How such information is being used will be explored in our review of the strategic delivery of police custody (paragraph 106).
R12	To further address inconsistencies in practice, Police Scotland should build on its approach to custody audit, with frequency of audits being reviewed and consideration given to additional cross cluster audits.	Open	From paragraph 10 for our continuing concerns about inconsistent practice. The reasons for inconsistencies and the existence of audit arrangements will be

	Consideration should also be given to a centralised resource to further support and undertake the additional work.		explored further in our review of the strategic delivery of police custody (paragraph 106).
R13	Police Scotland should develop a custody training strategy and implementation plan. This should be informed by a training needs analysis which covers all staff working within custody.	Open	Police Scotland has established a Criminal Justice Services Training Panel to provide governance around national training demands for custody. The work of the Panel and the development of any training strategy will be considered in our review of the strategic delivery of police custody.
R14	As a matter of urgency, Police Scotland should finalise the Custody Estate Strategy and work in partnership with the Scottish Police Authority and Scottish Government to prioritise investment in the custody estate.	Closed	August 2018. This recommendation has been superseded by Recommendation 1 in this report. Paragraphs 6-9.
R15	Police Scotland should seek to engage with its stakeholders as part of its development of a strategic proposal for custody ensuring that there is a shared vision and that further opportunities for joint working are optimised.	Open	This will be considered in our review of the strategic delivery of police custody.
IA1	Ensure that proportionate risk management procedures are in place to ensure effective detainee control at the point of arrival at custody centres.	Closed	August 2018. Paragraph 42.
IA2	Review custody policy to ensure that detainee PNC/SCRO checks are completed at the earliest opportunity and prior to presentation at the charge bar.	Closed	January 2016.
IA3	Review the appropriate roles and responsibilities of custody supervisors, police officers and PCSOs and ensure a consistent application of policy particularly when undertaking risk assessment.	Closed	January 2016. The custody supervisor retains oversight of all booking in processes.
IA4	Ensure that detainee property is stored in fully secure and/or CCTV monitored locations.	Closed	January 2016.
IA5	Develop a checklist for custody staff at the point of cell entry which is incorporated into custody policy to improve the consistency of communication with detainees – and is included in the regular audit process for assurance purposes.	Closed	January 2018. Paragraph 30 of *Inspection of custody centres located in Tayside Division* (2018).
IA6	Conduct a review of the operation of the custody centre at St Leonard's, Edinburgh.	Closed	January 2016. Action superseded by the report *Inspection of Edinburgh Division* (2015).
IA7	Undertake full risk assessment of vehicles used for detainee transfer for longer journeys.	Closed	January 2016.
IA8	Further investigate using court cells at Livingston and other viable locations at weekends to increase capacity in the area.	Closed	Police Scotland investigated the possibility of using the court cells at Livingston but this proved impracticable for several reasons.
IA9	The handover process should be as inclusive as possible involving, as a minimum, custody supervisors who should	Closed	January 2016.

	fully cascade details to their teams after their one-to-one handover.		
IA10	Consider a more formalised pre-release process to assure, as far as possible, that detainees will be safe after release from police custody.	Closed	August 2018. Paragraph 72.
IA11	Conditions for observing officers are often cramped and custody supervisors should ensure that observation time is limited for each officer with regular breaks.	Open	Paragraph 38.
IA12	Undertake further risk assessment of Hamilton, Paisley and Kirkcaldy custody centres of both health and safety and security with the engagement of staff associations and unions.	Closed	September 2015. Work was undertaken to identify improvements at these centres. Paisley is no longer used as a custody centre.
IA13	Review CCTV usage and camera positioning and make necessary adjustments.	Closed	January 2018. CCTV was reviewed during security audits of custody centres.
IA14	Review police officer and staff personal protective equipment, first aid and any other appropriate equipment.	Open	This will be considered in our review of the strategic delivery of police custody.
IA15	Consider the provision of smoke detectors or sensors within all cells as part of the estate investment programme.	Closed	January 2016.
IA16	Consider consistent provision of food and drink and balance cost efficiency with quality and take up levels.	Closed	September 2015.
IA17	Implement a consistent needs-based approach to the provision of bedding and clothing.	Open	From paragraph 68.
IA18	Extend the availability of foreign language reading materials in conjunction with community groups reflecting local demographics.	Closed	Paragraph 70. While work has been carried out to extend the availability of foreign language materials, availability will inevitably fluctuate and requires on-going monitoring.
IA19	Consideration should be given to extending availability and training in the use of accessibility facilities.	Open	Alongside other training related issues, this will be explored further in our review of the strategic delivery of police custody.
IA20	Review core training to consider the inclusion of procedures to follow when contacting solicitors and the handling of young detainees (including the *Getting it Right for Every Child* agenda).	Closed	January 2016.
IA21	Consider the national requirement and engage at an appropriate level with providers of adult services to highlight and address any issues with consistent provision of appropriate adults.	Closed	January 2016. Paragraphs 92-95, including reference to a recent Scottish Government consultation on establishing a statutory appropriate adult service.
IA22	Engage with NHS partners to consider the requirement for consistency of type and location of life-saving equipment and training in its use.	Open	Paragraph 103.
IA23	Consider widening access to training in mental health awareness and further developing effective policy guidance on the management of detainees with mental health issues.	Closed	September 2015.

IA24	Reflect the restrictions on the extent and availability of data from the eight legacy force ICT systems in the Police Scotland custody and corporate risk registers with suitable mitigation actions.	Closed	January 2016.
IA25	Implement more effective and proactive consultation and engagement with staff when developing custody policy and plans, and specifically when developing the future strategic proposal.	Closed	January 2016.
IA26	Explore other structural options within the new strategic proposal to ensure that the rationale for a single division remains valid and criteria established to allow proper evaluation.	Open	This will be considered in our review of the strategic delivery of police custody.
IA27	Check that the adverse incident processes in place ensure consistency of approach.	Open	The recording of adverse incidents will be considered in our review of the strategic delivery of police custody.
IA28	Develop robust internal governance to ensure improvement has been implemented and verifies that the desired impact has been realised. Consider sharing lessons learned with key partners, including independent custody visitors, to refine the approach further. Ensure that complaints analysis effectively contributes to the improvement process in the division.	Open	This will be considered in our review of the strategic delivery of police custody.
IA29	Consider and fully assess flexible options for both the level of responsibility and remuneration associated with sergeant or acting sergeant in custody centres.	Open	This will be considered in our review of the strategic delivery of police custody.
IA30	Consider the appropriate staffing model to address associated risks with custody staff undertaking a dual role (public counter role and custody role).	Open	This will be considered in our review of the strategic delivery of police custody.
IA31	Implement the Police Scotland Performance and Development Review process at the earliest opportunity to help consistently identify individual training and development needs.	Closed	January 2018. The implementation of a performance review process is addressed in HMICS, *Local Policing+ Inspection Programme – Inspection of Tayside Division* (2017), from paragraph 65.
IA32	Consider both staffing structures and development programmes for PCSOs in the Custody Division workforce plan.	Open	This will be considered in our review of the strategic delivery of police custody.
IA33	Review the divisional awards scheme in consultation with staff to ensure it achieves its purpose and align the scheme to the wider force Recognition and Reward framework to ensure consistency with other areas of Police Scotland.	Open	This will be considered in our review of the strategic delivery of police custody.
IA34	Implement a plan to attract high calibre officers as part of wider workforce planning to develop the division.	Open	This will be considered in our review of the strategic delivery of police custody.
IA35	Consider improved engagement mechanisms with staff to improve two-way communication and provide opportunities to address concerns and participate in the	Open	This will be considered in our review of the strategic delivery of police custody.

	planning process, discuss issues and provide feedback.		
IA36	Maintain accessibility at custody centres for key stakeholders and consider a standard control centre response to those who require entry.	Closed	January 2016.
IA37	Maintain dialogue with analytical services to ensure a dedicated analytical resource is available for advice and guidance in development of options to meet the gap until delivery of an integrated ICT solution.	Closed	September 2015.
IA38	Empower the new custody command team to maintain and develop external and internal (including local policing) relationships further.	Closed	September 2015.
IA39	Review and define clearer responsibilities between Criminal Justice and Custody Division in terms of partnership working and delivery of the Making Justice Work programme.	Closed	September 2015.
Inspection of custody centre located in Aberdeen City Division (2015)			
IA1	Custody Division should assess demand and ensure that a sufficient number of custody staff on each shift at Kittybrewster are trained to carry out checks.	Open	To be considered during the next HMICS visit to Kittybrewster, which may take place during our review of the strategic delivery of police custody.
IA2	Custody Division should ensure that custody staff make use of interpreters whenever needed, in accordance with Police Scotland policy.	Open	
IA3	Custody Division should encourage custody staff to provide and record a more detailed rationale for their risk assessment and care plan.	Open	Paragraph 22.
IA4	Custody Division should ensure that age is taken into account alongside other factors when carrying out risk assessments in custody. Risk assessments should also take account of whether it is a detainee's first time in custody.	Open	Paragraphs 25 and 33.
IA5	Custody Division should ensure that male and female detainees are held in separate areas within the cell accommodation wherever possible.	Closed	Superseded by Recommendation 3 in *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016).
IA6	Custody Division should review the availability of adaptations or aids at Kittybrewster to improve accessibility of cells used by detainees with mobility difficulties.	Open	To be considered during the next HMICS visit to Kittybrewster, which may take place during our review of the strategic delivery of police custody.
IA7	Custody Division should review the washing facilities at Kittybrewster.	Open	As above.
IA8	Custody Division should satisfy itself that it has identified the correct resourcing model for Kittybrewster.	Open	As above.
Inspection of custody centres located in Edinburgh Division (2015)			
R4	Police Scotland should develop and implement a strategy for the effective management of custody demand in the Edinburgh area.	Open	While some progress has been made, such as opening an additional booking in desk at St Leonards to help ease queuing, HMICS will

			consider this along with other estate issues during our review of the strategic delivery of police custody.
R5	Custody Division should ensure that staff complete Person Escort Records with all relevant risk factors. Reviewing Person Escort Records should form part the division's quality assurance process.	Closed	January 2018.
R6	Custody Division should establish an efficient process for ordering and maintaining supplies.	Open	While a new ordering process has been implemented, we continue to note issues (paragraph 68).
R7	Custody Division should urgently assess whether the vehicle used to transfer detainees from St Leonards on journeys outwith the city is fit for purpose and identify a more suitable vehicle if needed.	Closed	January 2018. The transfer vehicle has been upgraded.
R8	Custody Division should review the state of readiness in its ancillary centres and strengthen the process under which centres are regularly checked.	Closed	August 2018. Checks of ancillary centres are now carried out and we identified no readiness issues in our current inspection.
Inspection of custody centres located in Dumfries and Galloway Division (2016)			
R1	Custody Division should monitor the length of time immigration detainees spend in police custody and, where necessary, liaise with relevant partner organisations to minimise the duration of their stay.	Closed	Monitored by the Force Custody Inspector with delays escalated to relevant partner agency.
R2	Custody Division should consider rationalising the ancillary custody estate in Dumfries and Galloway, taking into account any impact on local policing.	Closed	Since our inspection, three of the eight ancillary custody centres we inspected in Dumfries and Galloway Division have been closed.
R3	If the ancillary custody centre at Sanquhar is to remain open, Custody Division should ensure that the water damage to the cells is repaired and new windows are installed.	Closed	The custody centre at Sanquhar is closed pending funding for repair work being approved and carried out.
Inspection of custody centres at Aikenhead Road and London Road, Glasgow (2018)			
R1	Police Scotland should explore why 15 and 30-minute observations are not being used in some custody centres and provide further guidance and training to staff where necessary.	Open	HMICS continues to find variations between centres in the use of 15 and 30-minute observations.
R2	A detainee's gender and dignity should be key considerations when allocating a member of staff to carry out constant observations. There should be a presumption, unless a risk assessment dictates otherwise, that constant observations should be carried out by someone of the same gender as the detainee.	Open	Paragraph 53.
R3	Wherever possible, male and female detainees should be held in separate areas within the cell accommodation.	Open	Paragraph 52.
Inspection of custody centres located in Tayside Division (2018)			
R1	Police Scotland should ensure that the toilet areas of cells monitored by CCTV are pixelated to preserve detainee privacy.	Open	Awaiting action plan from Police Scotland in response to this recommendation.

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About Her Majesty's Inspectorate of Constabulary in Scotland

HMICS operates independently of Police Scotland, the Scottish Police Authority and the Scottish Government. Under the Police and Fire Reform (Scotland) Act 2012, our role is to review the state, effectiveness and efficiency of Police Scotland and the Scottish Police Authority. We support improvement in policing by carrying out inspections, making recommendations and highlighting effective practice.

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