HMICS

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND

Inspection of custody centres in Greater Glasgow Division

June 2019

Improving Policing Across Scotland

npm national preventive mechanism

Produced and Published by Her Majesty's Inspectorate of Constabulary in Scotland

ISBN: 978-1-910165-52-2

Laid before the Scottish Parliament by Her Majesty's Inspector of Constabulary in Scotland
under section 79(3) of the Police and Fire Reform (Scotland) Act 2012
HMICS/2019/05

www.hmics.scot

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]

We are a member of the United Kingdom's National Preventive Mechanism, a group of organisations which independently monitor places of detention, including police custody, under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.[3]

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

[1] Chapter 11, Police and Fire Reform (Scotland) Act 2012.
[2] HMICS, *Corporate Strategy 2017-20* (2017).
[3] For more information, see https://www.hmics.scot/about-us/what-we-do/national-preventive-mechanism-npm.

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Our inspection

The aim of this inspection was to assess the treatment of and conditions for those detained in police custody centres located in Greater Glasgow Division. The division is served by four primary centres at Aikenhead Road, Govan, London Road and Stewart Street, and an ancillary centre at Baird Street. The inspection was linked to our review of local policing in Greater Glasgow Division, published in March 2019.[4]

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 eight custody inspection reports.[5] Our most recent report focusing on treatment and conditions in custody centres was published in October 2018 and was based on findings from the inspection of 17 custody centres across Scotland.[6] While some progress has been made in implementing previous recommendations and improvement actions, our inspection of custody in Greater Glasgow has continued to identify some of the same issues and areas for improvement, adding further weight to previous findings. This report contains five new recommendations. Many of our comments in relation to custody centres in Greater Glasgow will be equally applicable to other custody centres across Scotland and should be taken into account in improvement planning by Police Scotland's Criminal Justice Services Division.

This custody inspection is part of an on-going programme of custody inspections which contribute 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.[7]

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 the treatment of and conditions for detainees. Our custody inspections which take place during our Local Policing+ Inspection Programme will predominantly be focused on these custody-specific outcomes, but we will also comment on other themes from our framework where appropriate.

[4] HMICS, *Inspection of local policing in Greater Glasgow Division* (2019).
[5] All our reports are available on our website at www.hmics.scot.
[6] HMICS, *Inspection of custody centres across Scotland* (2018). We have since carried out an inspection focusing on the strategic arrangements for the delivery of police custody rather than the treatment and conditions in custody centres – HMICS, *Inspection of the strategic arrangements for the delivery of police custody* (2019).
[7] For more information about the UK NPM, visit www.nationalpreventivemechanism.org.uk.

Our inspections of the four primary custody centres located in Greater Glasgow Division were unannounced and took place in January 2019. In advance of our visits, we analysed a sample of custody records relating to 75 detainees. During our visits, we assessed the physical environment, interviewed detainees, custody staff and other professionals working in the custody centre (such as nurses) and observed key processes. We also took into account the views and experiences of officers and staff working in Greater Glasgow Division, and engaged with local independent custody visitors. Unannounced visits can limit what we see during our inspections as we may only observe what we find at the time of our visit. We also inspected the ancillary custody centre at Baird Street. The centre had not been used to hold detainees for several months prior to our inspection, and so our visit focused on the physical conditions of the facility.

HMICS wishes to thank the officers and staff of Criminal Justice Services Division for their assistance during our inspection. The inspection was carried out by Laura Paton and Tina Yule with support from our associate inspectors. On our visit to the custody centre at London Road, we were joined by the Scottish Human Rights Commission, and by Criminal Justice Inspection Northern Ireland on our visit to Govan. Both organisations are fellow members of the UK's NPM.

Gillian Imery QPM
Her Majesty's Chief Inspector of Constabulary
June 2019

Key Findings

- Staff working at the custody centres in Greater Glasgow were professional and respectful and the detainees we spoke to were generally satisfied with how they were treated.
- Custody resourcing has recently increased with additional Criminal Justice Police Custody and Security Officers and new team leaders being appointed.
- The physical condition of the Aikenhead Road custody centre has improved since our last inspection in 2016.[8]
- Local policing officers in Greater Glasgow raised a high degree of concern regarding queueing and processing times at all custody centres in the area.
- The reduced number of full-time custody centres in the division increases the time some arresting officers spend travelling with their detainees to reach their nearest centre.
- Prisoner Escort Records were not always completed with all relevant information.
- A new policy of allowing lower risk detainees a period of three hours continuous rest or sleep without the need for hourly rousing had recently been introduced.
- There is a much greater use of constant observations in custody centres in Greater Glasgow (and in the West generally) compared to other areas. This has an impact on the resources available for local policing and requires further analysis.
- With the increase in custody staff, custody supervisors should increasingly look to cover constant observations from within custody where possible, rather than drawing on local policing resources.
- At the time of our inspection, there was a lack of observation and accessible cells across Greater Glasgow. The number of observation cells has since been increased.
- There were effective handovers between shifts, with good briefing of incoming teams on the history and needs of individual detainees.
- The quality of the pillows, mattresses, blankets and towels available in custody has improved.
- There is a need to improve the recording of information about a detainee's time in custody.
- There is a need to ensure that all detainees in custody are aware of their legal rights and are able to exercise them. Some detainees would benefit from being reminded of these, after they have initially been booked in.
- Detainees across Greater Glasgow benefit from full-time nurse-led health care provision based at Govan custody centre. However, a greater degree of medical confidentiality for detainees is needed.

[8] HMICS, *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016).

Recommendations

Recommendation 1
Police Scotland should reconsider how it can better manage custody queue levels and provide radios to large custody centres to improve communication inside the centre and with local policing.

Recommendation 2
Police Scotland should ensure that the content of Prisoner Escort Records is reviewed shortly prior to detainees' release from police custody so that all relevant information about their time in custody is included.

Recommendation 3
Police Scotland should analyse risk assessment and care planning variances to check whether they are justified and to ensure a consistent approach across Scotland.

Recommendation 4
Police Scotland should ensure that ancillary centres are visited at least twice a year and reviewed for suitability ensuring everything present is up to date including posters, guidance, supplies and consumables.

Recommendation 5
Police Scotland should improve the adequacy and quality of information being recorded in custody by providing guidance and training to staff and by using quality assurance and audit processes.

Context

1. Custody is delivered throughout Scotland by Criminal Justice Services Division (CJSD). This division is one of several national divisions which sit alongside and support the 13 local policing divisions. A single, national division was established 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[9] and, in turn, to the Deputy Chief Constable for local policing. Custody is delivered in accordance with the custody standard operating procedure (the 'custody policy').[10]

2. Custody centres in Scotland are organised into clusters, each led by an Inspector. The custody centres at London Road, Stewart Street and Baird Street make up Cluster 7 and the centres at Aikenhead Road and Govan make up Cluster 9. The centres at Aikenhead Road, Govan and London Road are permanently staffed and open to receiving detainees at any time. At the time of our inspection, the centre at Stewart Street had moved to weekend-only opening hours and Baird Street had not been used since May 2018. The three full-time primary custody centres are each staffed by five teams working shifts. Stewart Street uses staff and officers from other centres and still relies on an element of local policing backfill. As an ancillary centre, Baird Street is only used on a contingency basis, such as when additional cell capacity across Glasgow is required or when another centre is closed for repairs.

Custody centre	Type	Number of cells	Throughput in 2018-19
Aikenhead Road	Primary	56	6,363
Govan	Primary	50	8,302
London Road	Primary	38	5,640
Stewart Street	Primary	46	4,597
Baird Street	Ancillary	36	171

PIRC investigations

3. The Police Investigations and Review Commissioner (PIRC) is an independent, statutory body whose role includes investigating the most serious incidents involving the police. Recommendations directed to Police Scotland by PIRC (and HMICS) are collated in an improvement plan which is overseen internally by the service's Senior Leadership Board and reported to the SPA. HMICS also has a role in following up on recommendations made by PIRC during the course of our own inspections.[11]

4. In the year prior to our inspection, there was one custody-related incident in Greater Glasgow Division which required investigation by PIRC. The investigation relates to the death of a 35-year-old man at Stewart Street on 30 May 2018. PIRC submitted its investigation report to the Scottish Fatalities Investigation Unit (SFIU) at the Crown Office and Procurator Fiscal Service on 19 December 2018 and the SFIU's decision on any proceedings is awaited.

[9] The custody portfolio is currently held by the Assistant Chief Constable (Local Policing East).
[10] Police Scotland, *Care and welfare of persons in police custody – standard operating procedure* (2018).
[11] *Memorandum of Understanding between the Police Investigation and Review Commissioner and HM Inspector of Constabulary in Scotland* (2018).

Independent custody visitors

5. Under the Police and Fire Reform (Scotland) Act 2012, the SPA is required to make arrangements for independent custody visitors (ICVs) to monitor the welfare of people detained in police custody.[12] Regular visits to custody centres are carried out by volunteers from the local community. Like HMICS, the independent custody visitors in Scotland are members of the UK's NPM. During our inspection, we engaged with local custody visitors regarding any recent issues they had identified at custody centres in Greater Glasgow. This information was used to inform our inspection.

6. In our 2018 report,[13] we noted that independent custody visitors often experienced unnecessary delays in gaining access to custody centres. We were told that this has improved in Glasgow following the designation of key Police Custody and Security Officers (PCSOs) to act as single points of contact with visitors to assist in expediting visits. However, some visitors were concerned that this new approach meant their contact with custody supervisors could be limited. The role of independent custody visitors had been included in the recently revised four week training course for newly appointed Criminal Justice PCSOs which HMICS welcomes.

[12] Chapter 16, Police and Fire Reform (Scotland) Act 2012.
[13] HMICS, *Inspection of custody centres across Scotland* (2018), paragraph 97.

Outcomes

Treatment and conditions

7. The primary custody centres in Greater Glasgow Division are all large, busy facilities located across the city. We visited all centres in January 2019. In terms of general condition, we found Aikenhead Road and Govan to be well maintained, however London Road was in need of significant investment. Stewart Street, although in reasonable condition, is based over four floors and is not viewed as offering a modern, secure custody environment. The layout of cells at Baird Street is similar to that at Stewart Street, except that central areas are inadequate to support a custody centre of its size. For example, there is a single booking in desk and no holding room or dedicated solicitor consultation room. In terms of the quality of the estate and facilities available, it is appropriate that CJSD has chosen to downgrade Stewart Street to weekend only opening hours and to designate Baird Street as suitable only for contingency purposes. However, in developing a long term custody estate strategy, CJSD should consider whether there is a need for a large, purpose-built custody centre in the Glasgow area, similar to Kittybrewster in Aberdeen.

8. In 2018, CJSD set out plans to designate London Road as the fourth of nine Criminal Justice Hubs across Scotland.[14] The process of establishing a Hub at London Road would have involved investment in and remodelling of the custody centre. However, Police Scotland's budget settlement for 2019-20 required it to review its financial planning for the year. This resulted in the expected funding for the Hubs being deferred while Police Scotland prioritised funding for other projects. We have noted elsewhere that business as usual funding decisions were taken in anticipation of dedicated funding for the Hubs, meaning some remedial estates work, including at London Road, may now be pressing.[15]

Arrival in and release from custody

9. Staff manage the arrival and departure of detainees as safely and securely as possible given some challenges posed by the physical environment. We found that all docking areas were within securely gated yards monitored by CCTV with Govan and Stewart Street having separate secure areas for detainee movements. However, the docking gate and CCTV at Stewart Street were not in full working condition when we visited despite having been reported for over six months. We observed a number of car parking spaces specifically designated for custody queueing in London Road but were told in other locations that parking can be challenging as yards are very busy.

10. On arrival, detainees may remain in holding areas pending checks being carried out to identify if there are any warning markers that may indicate, for example, a history of violence or self-harm. At busier times, detainees may also be held in these areas until a booking in desk and custody staff become available to process them. At London Road in particular, the detainee holding area is small. This results in queues forming outside and detainees being held in police vehicles. The route to booking in is via this small holding area which is not ideal.

11. Holding rooms in Aikenhead Road and Govan were glass-fronted and well-positioned within sight of the booking in desks. This allowed easy monitoring of detainees waiting to be booked in. Staff at all centres stated that they would prioritise young people, drink drivers and any disruptive detainees.

[14] For further information about Criminal Justice Hubs, see HMICS, *Inspection of the strategic arrangements for the delivery of police custody* (2019).
[15] HMICS, *Inspection of the strategic arrangements for the delivery of police custody* (2019), paragraph 142.

12. Local policing officers in Greater Glasgow Division raised a high degree of concern regarding long queueing and processing times at all custody centres in Glasgow.[16] This was a particular issue at weekends when custody centres can be busier. Their perception was that this impacted directly on their availability to respond to other incidents in their communities.

13. We found evidence to support this perception of longer processing times from our analysis of custody records relating to 75 detainees held at the four primary custody centres in Glasgow.[17] At Govan, for example, while some detainees were booked into custody soon after arrival, others waited a significant period. The longest in our sample was 110 minutes. This would merit further analysis by CJSD, to assess waiting times at different centres and at different times. This information could be used to better inform its custody estates strategy as well as its resourcing model, and to address unnecessary delays which impact directly on local policing divisions.

14. Custody staff confirmed that queues often formed. However, they felt the booking in process could be expedited if arresting officers routinely notify the custody centre that they are en-route with a detainee, in accordance with the custody policy. This gives custody staff the opportunity to start carrying out checks on the detainee even before their arrival. Custody staff also said that if arresting officers phone ahead, they can be informed of any queues and advised to go to another custody centre where their detainee may be processed more quickly. However, local policing officers told us they were reluctant to phone in advance as they feared being redirected to another centre further away, and did not trust that this would result in them being able to return to their usual duties more quickly.

15. The provision of real-time information on queue length and likely processing time was raised as a potential improvement area. Some local policing officers felt that Contact, Command and Control Division (C3) could better assist by routing officers to the most appropriate custody centre as part of its incident management role. We established that C3 supervisors currently have access to the National Custody System (for the purpose of checking whether any missing persons are in custody), but this access is not available throughout C3 and cannot provide up to date information on queueing times.

16. HMICS notes that the CJSD Continuous Improvement Team had previously proposed the use of a dynamically updated intranet page to hold information on cell occupancy and queue lengths at each centre. This page would be updated by custody staff and could be accessed easily by arresting officers via C3. This proposal, called 'Cell Checker', was originally suggested in November 2017 but not taken forward.

17. We believe that CJSD should re-consider how it can better manage queue lengths and communications with arresting officers in this regard. We also consider that communications could be improved with the provision of radios to large custody centres (accepting that, in some, building reception can be limited). This would support both communication between custody staff, C3 and officers travelling with detainees.

Recommendation 1

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

[16] HMICS, *Inspection of local policing in Greater Glasgow Division* (2019), paragraphs 143 to 148.

[17] In total, 75 records relating to detainees held at the four centres were examined (20 from Aikenhead Road, 25 from Govan, and 15 each from London Road and Stewart Street). The records sampled were from November 2018, a few weeks prior to the records analysis taking place. No records from Baird Street were examined as no detainees had been held for several months prior to our inspection.

18. We observed effective booking in processes at all locations with some examples of good rapport being established with detainees. However, varying approaches were taken to booking in by custody supervisors across Glasgow and this directly affected queuing and processing times. These varying approaches had also been highlighted to us by local policing officers.

19. The booking in process is carried out or overseen by the custody sergeant. We noted that some sergeants prefer to undertake this themselves, thus restricting the number of detainees who can be booked in at any one time. In contrast, other sergeants delegated the process to PCSOs. While there were two or three booking in desks available at each of the primary centres, we were told that depending on the sergeant, sometimes only one would operate, even at peak times, whereas others would allow all desks to operate with their oversight. The sergeants and the custody staff we interviewed were clear that this decision related to risk assessment, availability of staff and safeguarding the privacy of detainees.

20. The layout of the booking in desks at all locations provided limited privacy and could often be noisy, but this could be managed by restricting the number of desks operating. In Stewart Street, the sergeant's desk was immediately to the rear of the booking in area and was in public view. We did not identify accessibility features at most of the booking in areas (lowered bars, private rooms, hearing loops etc) but did observe one detainee being provided with a chair and a hearing loop at Stewart Street.

21. We noted that storage capacity for detainee property was limited in some centres, with coats and shoes instead being left in corridors outside cells representing a trip hazard. We also observed that new CellSense[18] detectors had been introduced which staff told us were effective. HMICS welcomes the deployment of such new technology in the custody environment.

22. In our sample of custody records, we found that 6.7% of detainees had been transferred from other custody centres. The reasons given were:

    - transfer from Greenock to Govan to benefit from on-site health care from nurse
    - transfer from Govan to London Road as there had been no constant observations capacity
    - two were transferred from Dunfermline and one from St Leonards in Edinburgh because of a lack of capacity in the East. One of the detainees transferred from Dunfermline had already been transferred from Levenmouth to Dunfermline.

23. Each morning, a private contractor attends custody centres to collect and escort those detainees who are due at court. We observed this process at Stewart Street and noted that it was working well. The private contractor at the time of our inspection was G4S, but the contract transferred to GeoAmey on 26 January 2019.

24. As part of our records analysis, we examined a number of Prisoner Escort Records (PERs). These records are completed by custody staff and given to the escort contractor as a means of sharing known risks about the detainee. While many were completed with all relevant information, we noted that some did not include information that had become known during the detainee's stay in custody and only included information available at the time of booking in. In one case, this meant important information about the health care and medication received by a detainee while in custody was absent. This suggests that PERs are being completed shortly after booking in and are not being updated prior to release. We have previously highlighted this issue and suggest that the content of all PERs is reviewed shortly prior to detainees' release from police custody.[19]

[18] CellSense equipment detects items containing ferrous metals, helping the police to identify whether detainees have mobile phones or other contraband secreted on their person.
[19] HMICS, *Inspection of custody centres across Scotland* (2018), paragraph 73.

Recommendation 2

Police Scotland should ensure that the content of Prisoner Escort Records is reviewed shortly prior to detainees' release from police custody so that all relevant information about their time in custody is included.

25. A pre-release risk assessment (PRRA) is also carried out for all detainees being released to determine whether they pose a risk to themselves or others. In Greater Glasgow, we found this typically involves a PCSO carrying out the assessment in the cell whilst preparing the detainee for departure. Custody staff told us that they felt this process was perfunctory, did not fully assess risk and that most detainees knew the answers to give to avoid delaying their release. However, custody sergeants told us that they would take advice from medical professionals regarding the physical and mental state of the detainee before releasing them and would verify PRRA answers with PCSOs and the detainee.

26. In our analysis of 75 custody records, we noted examples of detainees being released from custody during the night with no information recorded as to how they would get home. We also saw examples of detainees who had been assessed as high risk and placed on constant observations being released with no information recorded regarding their state of health, intoxication or demeanour at the point of release. In these cases, it was not clear whether action had been taken to risk assess and manage detainees but not recorded, or whether insufficient action had been taken.

27. During the PRRA process, there is an opportunity for detainees to be referred to other agencies for support. We found such referrals to be rare. While most custody staff told us that they will ensure that ex-armed forces detainees are made aware of support services, they said most other detainees are already 'in the system' and are therefore reluctant to engage with referral schemes. Staff also told us that partner agencies who routinely visited people in custody in the past no longer attend. We are aware that work is ongoing by CJSD to increase the presence of partner organisations in custody to provide greater support and intervention opportunities for detainees.[20] Generally however, HMICS believes there is scope for PRRA and referrals processes to be developed further.

Risk assessment

28. During the booking in process, a risk assessment is carried out for every individual who comes into police custody. Effective risk assessment is vital 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, medical history etc. We were able to observe the vulnerability questionnaire being delivered at each of the primary centres. We also reviewed additional risk assessments via our sample of custody records.

[20] HMICS, *Inspection of the strategic arrangements for the delivery of police custody* (2019).

29. The initial risk assessment process concludes with custody staff determining a care plan for detainees. This involves determining whether the individual is high or low risk, and what level of observation they should receive. Shortly before our inspection, a new approach to observations and rousing had been introduced. Previously, observations were either constant or at 15, 30 or 60-minute intervals and all detainees were roused at least once every hour.[21] The new approach is more nuanced and is based on an assessment of risk, threat and vulnerability. Detainees will now be subject to observations and rousing according to the following scale:

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

30. We welcome CJSD's efforts to review and update its approach to observations and the additional guidance now set out in the custody policy. The new policy addresses our previous recommendation that the division review its approach to rousing all detainees at 60-minute intervals, regardless of risk and should allow some detainees longer periods of uninterrupted sleep.[22] We will continue to monitor the implementation of the policy in future custody inspections. In Greater Glasgow, where the policy had only recently been introduced, custody staff were still familiarising themselves with the new approach and some seemed uncertain as to whether it was being trialled or whether it reflected a permanent change in policy.

31. The responses to the vulnerability questionnaire and the subsequent care plan are recorded on the National Custody System (NCS) which has been in use across Scotland since early 2017. The system is generally viewed positively by custody staff, although local policing officers did perceive that the system and vulnerability questionnaire were contributing to slow processing times. Custody staff acknowledged that the question set could take some time to complete for some detainees. They felt there was some duplication among the vulnerability questions, and said that system issues sometimes meant them having to start again from the beginning. We also heard that logging a detainee's property on the system can take some time, again impacting on processing and queuing times.

32. In the 75 custody records we reviewed, 36.0% detainees was assessed as high risk and 64.0% were assessed as low risk. In 10.7% of the cases where risk was assessed as low, we considered the information on the record suggested the risk should have been high. The information often related to alcohol and drug use and withdrawal symptoms, coupled with other health conditions, which indicated a high risk, which could be reviewed and reassessed as time passed.

[21] Rousing involves gaining a comprehensive verbal response from a detainee, even if it involves waking them while sleeping. If a detainee cannot be roused, they should be treated as a medical emergency.
[22] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Recommendation 7.

33. Generally, however, our analysis identified that there was some degree of risk aversion in the records reviewed and that detainees appeared more likely to be assessed as high risk and requiring constant observations than in other centres we have inspected (constant observations were required in 30.7% of cases). Where risk existed, the default response appeared to be constant observations mostly via CCTV, with minimal 60-minute rousing. Thirty-minute checks were only used in two cases out of 75. Fifteen-minute checks were only used in one case on the instruction of a doctor.

34. We did not consider these seemingly risk averse assessments to be incorrect, but deferred to the judgement of the custody staff who made the assessment and who considered the detainee to pose a sufficiently high risk requiring constant observations. However, we have noted in previous inspections that constant observations may have been used too readily in some areas when other options may have been available and are concerned that this issue is ongoing.[23] Local policing officers in Glasgow also felt that custody care plans were too risk averse, and constant observations were used in cases where it was not necessary. Indeed, information recently gathered from NCS shows that constant observations are used at a much higher rate in Glasgow and the West of Scotland generally, compared to other areas (see Table 1).

Table 1 – Use of constant observations in custody 2017-18 and 2018-19[24]

	North clusters			East clusters			West clusters						Force
	1	2	3	4	5	6	7	8	9	10	11	12	
% constant observations 2017-18	8.0%	1.0%	4.0%	2.0%	7.7%	4.1%	26.4%	14.5%	25.1%	18.7%	28.8%	26.2%	14.5%
% constant observations 2018-19[25]	8.8%	1.8%	5.0%	3.0%	6.9%	3.1%	29.4%	28.1%	31.9%	19.1%	33.7%	28.5%	16.7%

35. Custody staff in Glasgow attributed the greater use of constant observations to the characteristics of their detainee population, citing high levels of substance misuse and health issues. While this may account for some disparity, we believe other areas experience similar issues and the disparity requires further investigation by CJSD to assess whether it is justified. This is important because constant observations may affect the detainee's privacy and dignity and are a very resource-intensive means of managing detainees. CJSD almost always relies on local policing officers to remain within the custody centre to carry out the observations which takes them away from their usual duties as community officers or responding to incidents. We have previously noted that local policing officers are used to conduct constant observations even when the custody centre is quiet and some custody staff had little to do.[26] This continues to be the case, with local policing officers being considered as the default option. As the number of custody staff increases and vacancies are filled, however, CJSD should increasingly look to cover constant observations from within its own staffing complement wherever possible.

Recommendation 3
Police Scotland should analyse risk assessment and care planning variances to check whether they are justified and to ensure a consistent approach across Scotland.

[23] HMICS, *Inspection of custody centres in Tayside Division* (2018), paragraph 18; *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016), paragraph 19.
[24] Data provided by Police Scotland.
[25] 2018-19 proportions relate to the period between April and October 2018.
[26] HMICS, *Inspection of custody centres at Aikenhead Road and London Road, Glasgow* (2016), paragraph 21.

36. From our records analysis, we considered the care plan to be incorrect in 17.3% of cases based on the information recorded:

- in the eight cases where we considered the vulnerability to have been assessed wrongly based on the information recorded, the subsequent care plan was also not appropriate
- in three cases, vulnerability was high but the care plan only required the minimum 60-minute observations. We have previously queried the purpose of assessing a detainee as high risk if no action is subsequently taken to manage the risk posed[27]
- in two cases, constant observations were used where a more proportionate risk mitigation plan may have been appropriate e.g. a young person assessed as high risk solely because of their age and put on constant observations, when perhaps more regular checks may have been appropriate.

37. We also found that observation levels were met satisfactorily in almost all cases. However, in one case, there was an almost two-hour gap between recorded checks when the detainee had previously been checked every 15 minutes, and there was no information on the record to support a change in observation level.

38. A number of other issues were also identified in our records analysis relating to risk assessment and observation levels:

- failure to indicate the appropriate rousal level when using constant observations via CCTV – this was often not included in the custody record as it should have been. Rousals remain important even when CCTV observations are taking place
- limited evidence of risk re-assessment during stays in custody, particularly an absence of downgrading from constant observations which has resource implications for local policing. However, we did find a good example where a detainee was moved from high to low risk after sobering up with a clear rationale recorded
- potential over-reliance on constant observations via CCTV rather than in person.

39. During our inspection, we observed effective shift handovers at all four primary centres. The sergeant or custody supervisor going off shift briefed the incoming supervisor about each detainee held, discussing any vulnerabilities and risks, care plans, and any other information. We also observed a number of good handovers taking place at the same time between PCSOs, although this was not consistent across all shifts or locations. CJSD should consider what role team leaders (where they exist) should play in shift handovers in future.

40. In our records analysis, 17.3% of detainees were strip searched. All strip searches were appropriately authorised although we observed different approaches to communicating with detainees about the need for a strip search. Some staff simply told the detainee that they would be strip searched, while others also informed them of the reason why. This should be done routinely.

[27] HMICS, *Inspection of custody centres across Scotland* (2018), paragraph 27.

Custody environment

41. As noted in our previous reports, the condition of the custody estate and its ongoing maintenance remains of significant concern to HMICS and is the subject of previous recommendations.[28] HMICS welcomes the improvement in the condition of Aikenhead Road since our last visit in 2016. We also noted the installation of new cell doors in London Road as well as new heating. The new kitchen and ventilated windows in Stewart Street are also welcome upgrades.

42. However, the condition of cells on the first floor of Stewart Street and old cell doors on upper floors require to be addressed. As noted at paragraph 8, the deferral of works at London Road to take advantage of the planned Criminal Justice Hub investment now leaves the centre in unsatisfactory condition.

43. We found the cells at the four primary custody centres to be a good size, and all had natural light with the exception of six cells at Aikenhead Road. Stewart Street had a number of very large cells available. All cells at each centre had low benches which limits accessibility for those detainees with mobility difficulties. No cells had call buttons within reach of the benches although there was an accessible wet room at Aikenhead Road (out of operation at the time of our visit). An accessible shower room and toilet were also available at Govan. Each centre had cells that could be monitored via CCTV, with pixelation on most monitoring screens of toilet areas to preserve detainee privacy. However, the toilets in four cells at London Road were not pixelated. We have previously recommended that Police Scotland should ensure that the toilet areas of cells monitored by CCTV are pixelated to preserve detainee privacy.[29] HMICS is aware that CJSD is actively addressing wider CCTV issues, but we note that this needs significant funding to fully address requirements across the country.[30] Since our inspection, CJSD has sought to implement a temporary fix to address the lack of pixelation, although a long term solution is still required.

44. Baird Street is used as a contingency centre and had not been used for several months prior to our inspection. We found the centre to be in relatively good condition given its limited usage. The custody centre has a ground floor with booking in area and four floors of cells with a lift. We found that facilities for booking in, visits and holding detainees prior to booking in were inadequate for a centre of its size. We also found that store cupboards and supplies required to be tidied and replenished with out of date materials removed. We were advised that if the centre was to be used, an advance team would be sent to check condition and supplies. HMICS recommends that centres such as this should be visited at least twice a year and reviewed for suitability ensuring everything present is up to date including posters, guidance, supplies and consumables. In centres that are used as infrequently as Baird Street, consideration should be given to removing any food, and instead ensuring fresh supplies are brought with the advance team when the centre is to be used.

Recommendation 4

Police Scotland should ensure that ancillary centres are visited at least twice a year and reviewed for suitability ensuring everything present is up to date including posters, guidance, supplies and consumables.

[28] See, for example, HMICS, *Inspection of custody centres across Scotland* (2018), Recommendation 1.
[29] HMICS, *Inspection of custody centres in Tayside Division* (2018), Recommendation 1.
[30] HMICS, *Inspection of the strategic arrangements for the delivery of police custody* (2019), paragraph 149.

45. HMICS notes that a similar recommendation has been made previously[31] and was subsequently closed after processes for regular visits were developed. However, we found that such processes were not being followed and have therefore repeated this recommendation.

46. During our inspection, not all cells were available in the centres we visited, with those unavailable awaiting cleaning or maintenance. We also observed and heard that there are a limited number of cells with CCTV across Glasgow. Staff told us that the number of CCTV cells in Greater Glasgow is insufficient to meet the detainee risk profile and the high level of constant observations. This limits the number of detainees who can be observed via CCTV and results in detainees being transferred between centres and out of Glasgow so that their needs can be met. We also observed poor quality of CCTV recording and viewing monitors in each centre, limiting the effectiveness of CCTV in managing risk. While HMICS has seen evidence of ongoing investment in the upgrade of CCTV systems across the custody estate, Greater Glasgow should be considered for prioritisation given its high throughput of detainees. Since our inspection, the number of CCTV cells at Govan has increased from 12 to 24 and the division has replaced all CCTV monitoring screens, which we welcome.

47. Cleanliness and hygiene at each custody centre were satisfactory although there was scope for more thorough cleaning of cell ceilings and upper walls in all locations. Many of the windows providing natural light, particularly those in the ceiling, were dirty and limited the light available. Effective ventilation also appeared problematic in a number of the cells we visited.

48. All four primary centres had cells with potential ligature points – these tended to be around ventilation and lighting panels, wash areas, old cell doors and call buttons. Staff seemed unaware of some of these ligature points and we would expect their existence and how they should be managed to be addressed in site specific risk assessments or any site induction protocol with which all staff are familiar and which are made known to any staff temporarily working at the centre.[32] Pillows (where used) and mattresses were in generally good condition and their quality was now being monitored. This represents an improvement on previous inspections when we had often found their quality to have been poor. Blankets and towels were all in good condition with many recently replaced as part of a national soft facilities management contract.

49. In our 2018 report,[33] we noted concerns about the quality and speed of repairs by contractors. Staff at Glasgow's primary centres consistently told us of their concerns regarding response and resolution of property-related issues. Staff showed us a number of examples of outstanding works (including docking gate, CCTV and solicitor phone at Stewart Street; water damaged ceiling in Govan; and shower leakage in London Road) and told us that they often raised these with independent custody visitors to help expedite a response. We also observed that the quality of some of the remedial work undertaken was unacceptable (such as the patching around cell light panels and call buttons in Govan).

Detainee care

50. We found custody staff on the whole to be professional and respectful, and the detainees we spoke to were generally satisfied with how they were treated.

51. There were no exercise yards at Stewart Street or London Road. Aikenhead Road has a facility which is not used. However, separate yards were available for male and female detainees at Govan. We were told that a pilot was to shortly commence to evaluate the practical implications of offering exercise routinely to detainees at this location. HMICS welcomes this development and notes that the additional staff now working in custody provide an opportunity to allow detainees fresh air and exercise.[34]

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[31] HMICS, *Inspection of local policing in Edinburgh Division* (2015), Recommendation 8.
[32] Further comment on the need for a site induction protocol is made in HMICS, *Inspection of the strategic arrangements for the delivery of police custody* (2019), paragraph 89.
[33] HMICS, *Inspection of custody centres across Scotland* (2018), paragraph 58.
[34] HMICS has previously recommended that Police Scotland review the availability of exercise for detainees – *Thematic*

52. We have generally found that washing facilities and showers are not routinely offered at many custody centres. There were no hand washing facilities in any of the cells in Glasgow, and detainees are not routinely offered (nor do they ask for) the opportunity to wash their hands after using the toilet or before eating. We also noted that some external toilet flushes were faulty in Govan.

53. At all four primary centres, showers were generally offered at weekends only. Our review of custody records showed that no detainees were recorded as having had showers, although 30.7% were recorded as having had a 'wash'. In our sample, some detainees were offered but refused a wash. Showers in Stewart Street had no screens or curtains and other than on the female corridor, appear not to have been used in some time. Staff in Govan told us they had recently been instructed to offer showers.

54. The shower at London Road was spilling large quantities of water, which had been reported for repair some time ago and was therefore not in use. We also noted that the shower and washing area in some centres was monitored by CCTV. It was not clear if cameras were switched off when the facilities were in use.[35]

55. Custody staff in Glasgow told us that a lack of resources was the main factor in showers not being offered more routinely. We have previously recommended that Police Scotland review the availability of showers for detainees and now consider that with the increased number of staff at these centres, showers should be offered more routinely.[36]

56. Staff were generally aware of the need to identify and cater for the religious needs of detainees. Religious texts and prayer mats were available, as were meals to suit a range of diets. While visiting one centre, HMICS advised staff on the correct storage arrangements for the Qur'an, an issue highlighted in a previous inspection report.[37] CJSD should ensure that custody staff across Scotland are aware of arrangements for the respectful storage of religious items.

57. We found that a good stock of reading material for detainees was maintained at each centre. Reading materials were also accepted from relatives/visitors and provided to the detainee after examination. However, there was no foreign language material, or suitable material for those with a learning disability or visual impairment, in any of the centres. We also noted in our interviews with detainees that custody staff did not always proactively offer reading materials.

58. At all centres, staff told us they would seek to keep male and female detainees in separate areas of the cell accommodation wherever possible, in keeping with custody policy and a previous HMICS recommendation.

59. There were good supplies of items required for detainee care and the general running of the custody centres with effective stock control by PCSOs in each centre. HMICS found that this process was more efficient and effective than that observed in other areas, where various levels of sign-off are required before stock can be ordered. CJSD should therefore consider a similar approach for national adoption. However, custody staff also told us that obtaining office supplies and consumables was extremely challenging due to budget restrictions.

inspection of police custody arrangements in Scotland (2014), Recommendation 8.

[35] We previously commented on the CCTV monitoring of wash and shower areas in HMICS, *Inspection of Aikenhead Road and London Road, Glasgow* (2016), paragraph 26.

[36] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), Recommendation 8.

[37] HMICS, *Inspection of custody centres across Scotland* (2018), paragraph 47.

60. Each interaction with a detainee and the detainee's movements around the custody centre (e.g. to see the nurse) should be recorded on a Prisoner Contact Record (or 'cell sheet'). This is a paper system, with Prisoner Contact Records placed outside each cell and updated by staff after every interaction. We found that the quality of entries on the records was generally poor, reflecting previous findings.[38] We also noted that electronic updates on NCS often differed from those noted on the Prisoner Contact Record.

61. At the custody centres in Greater Glasgow, we noted that sometimes blanket or 'batch' updates are applied to all custody records. The previous custody system allowed these updates to be applied automatically to all records, whereas the NCS does not. Instead, users are cutting and pasting the same entries to each record. This sometimes results in information about one detainee being included on the records of all detainees, and may limit the addition of more appropriate, detainee-specific updates which properly reflect staff interactions with individuals. We are aware that PIRC has also raised concerns about such updates during its investigations, and suggest that CJSD reviews this approach and considers whether it is necessary and appropriate.

62. During this and previous inspections, HMICS has raised concerns about the assessment and care of detainees based on the sometimes limited information recorded on the custody system, and has observed unsatisfactory recording of information during our visits. Poor recording of information also affects the quality of data extracted from the NCS. Despite our repeated commentary, the recording of appropriate information continues to be an issue. This is an area that should be targeted for improvement via guidance, training, recording standards, quality assurance and audit.

Recommendation 5
Police Scotland should improve the adequacy and quality of information being recorded in custody by providing guidance and training to staff and by using quality assurance and audit processes.

Legal rights

63. Appropriate grounds for detention existed for the detainees in custody at the time of our inspection, and the detainees were held for no longer than was required. Most detainees appeared to have been provided with a Letter of Rights (a booklet setting out their rights). Upon being given his Letter of Rights, we observed one detainee saying he could not read, but no further action was taken to assist him. In our records analysis, we also noted some cases where the detainee reported not being able to read or write but no information was recorded on how this was managed (for example, by reading or explaining legal rights to the detainee, or by seeking the assistance of an appropriate adult). Not all staff knew of the availability of an 'easy read' version of the Letter of Rights. All custody staff should be reminded of the need to ensure that detainees are aware of and understand their rights.

64. We observed a good example of booking in with an interpreter at Aikenhead Road, where the detainee's understanding of the process and their rights was repeatedly checked and the process slowed deliberately to allow the detainee to ask questions. Staff told us that there can be some issues accessing interpreters for rarer languages as sometimes only one interpreter is available for the whole of Greater Glasgow or the West.

[38] HMICS, *Inspection of Aikenhead Road and London Road, Glasgow* (2016), paragraph 29.

65. While observing detainees being booked into custody and read their rights, we noted that the process appeared repetitive and caused confusion for some detainees.[39] This was not helped by the PIROS[40] procedure at times being delivered by rote, with a lack of intonation and eye contact and, in some cases, failure to verify that the detainee had really understood what they were being told. Custody staff should be reminded that this procedure is critical to ensuring the rights of detainees are safeguarded, and should be delivered effectively. Some staff may benefit from refresher training in this area.

66. During our discussions with individuals being detained at the time of our inspection, we noted that several appeared not to remember where or why they were in custody and were not aware of key details, such as whether they had asked for their solicitor or another reasonably named person to be made aware of their detention. This may be because some detainees were inebriated at the time of booking in. In this case, it is essential that detainees are reminded of their legal rights once they have sobered up and that this is recorded. In other cases, it appeared to us that detainees had not fully understood or taken in their rights at the point they were booked in. These detainees would benefit from time to reflect on their situation, and being asked again at a later point whether they would like to exercise their rights. While we have seen this being done in previous custody inspections, the number of detainees who seemed unaware of their situation in Greater Glasgow suggests this could be done more routinely.

67. Appropriate adults were not used for any detainees during our inspection, but we noted their use in some of the custody records we reviewed. Custody staff told us that accessing this service out of hours, at weekends and across local authority boundaries can be challenging.

68. During our inspection, we heard from custody staff that arresting officers often did not take their detainee to the nearest custody centre, but instead to the centre nearest their own base of operations, often bypassing other custody centres en-route. This meant detainees travelling greater distances before information about their vulnerability and risks is fully known, and may take them further from their contacts and support mechanisms, such as family members, solicitors and appropriate adults. Custody staff felt this additional travelling was done to suit the needs of officers rather than detainees, however some arresting officers told us they sometimes travelled further to access better quality interview rooms or to avoid waiting in queues at busy centres. Indeed, we observed that the quality of interview rooms at some centres was poor. CJSD should use data drawn from NCS relating to arrest location and chosen custody centre to explore this issue further and identify what, if any, action is needed to help manage risk and ensure detainees can access the support they need. We previously reported on this issue in 2016 but, at the time, the NCS was not in place and the necessary data not easily retrieved.[41]

[39] We noted similar concerns in HMICS, *Inspection of custody centres across Scotland* (2018), paragraph 85.
[40] Police Interview – Rights of Suspects.
[41] HMICS, *Inspection of Aikenhead Road and London Road, Glasgow* (2016), paragraph 40.

Health care

69. Health care at the custody centres in Glasgow is provided by NHS Greater Glasgow and Clyde. Nurses are permanently based within the Govan custody centre and may travel to visit detainees across Glasgow as well as Greenock and Clydebank. If a person detained at Aikenhead Road, London Road or Stewart Street requires on-going care, they may be transferred to Govan. There are usually at least two nurses on duty, with this number increasing up to five at weekends. One nurse usually remains at Govan to cover the phone and monitor any detainees with Type 1 diabetes, while others can take a more peripatetic role.

70. We were told that around half of the nursing team are mental health nurses able to undertake mental health assessment in custody. However, the nurses and custody staff we spoke to told us it was often challenging to access such assessments from other health care disciplines such as psychiatry.

71. One of the issues most often raised during our discussions with detainees was their frustration about delays in accessing medication. We were informed that the local policy is that nurses will see detainees within the first six hours in custody but will not prescribe medication within that time as they cannot be sure if other medication or substances have been taken. Exceptions to this policy are made for those detainees with particular health concerns, such as Type 1 diabetes.

72. During our inspection, we were concerned at the lack of medical confidentiality for detainees. We observed that the medical room door was left open during medical consultations with custody staff in close proximity. This appeared to be regardless of the risk posed by the detainee. Nurses told us that in particularly sensitive cases the door would be closed, but that a member of custody staff would generally remain inside the medical room. We would expect that detainees are able to speak with health care staff in confidence, unless a risk assessment determines otherwise.

73. We were also told that two custody staff escort detainees to the medical room and wait throughout their medical consultation. This is resource intensive and can impact the effective running of the custody centre at busier times. We have noted that practice in this respect varies across Scotland and believe that one member of staff may be sufficient based on an assessment of risk.

74. Adastra is a national IT system for recording health care in police custody and forensic medical services. Health care staff are able to access local information about detainees, and can use regional portals to access information about a detainee if they are from another health board area. However, where such access is not possible, we were surprised by resistance to contacting custody-based health care staff in the relevant area to access the necessary information on their behalf. We were told that a health care practitioner would not share information because they would not be able to verify the identity of the practitioner requesting it and would not be able to check that the patient was in fact in custody. However, all custody-based health care practitioners in Scotland would be able to ask custody staff to access NCS to check that a named individual is in custody and we consider that more could be done to establish relationships between health care staff at custody centres so that information can be shared when necessary.

75. In our records analysis, we found that a health care practitioner was required in almost a quarter of cases. While most detainees who required a health care practitioner had access to one, there were some cases where it was not clear from the record whether detainees had seen a nurse or doctor. In three cases, a detainee asked to see a nurse or be taken to hospital but there was no indication of any action being taken in response, or justification for why the request was not met. In one case, a health care practitioner should have been contacted given the detainee's history and whilst a note was made that a nurse would be phoned for medication, there was no further record of what happened. This adds weight to Recommendation 5, that there is a need to improve record keeping in custody.

76. In terms of health care facilities, equipment and supplies, we noted that several first aid kits were to be found in all custody centres, but their contents were inconsistent and the kits were sometimes incomplete and out of date. We also found that some supplies held within medical rooms were out of date. The medical room in Stewart Street was found to be very compact and not maintained to the standard observed elsewhere. However, we welcome that the Govan centre was accommodating detainees requiring access to CPAP[42] machines who experience breathing issues associated with sleep apnoea. We also noted during our inspection that nicotine replacement therapy for detainees has been successfully piloted at Govan and will be rolled out across Scotland.

77. We acknowledge the limitations of our ability to assess health care provision effectively, and have repeatedly sought the participation in our inspections of Healthcare Improvement Scotland (HIS), the regulatory and scrutiny body for the NHS. We are pleased that it seems these efforts have been successful and we expect to conduct inspections of police custody jointly with HIS In 2020-21.

[42] Continuous Positive Airway Pressure.

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ISBN: 978-1-910165-52-2