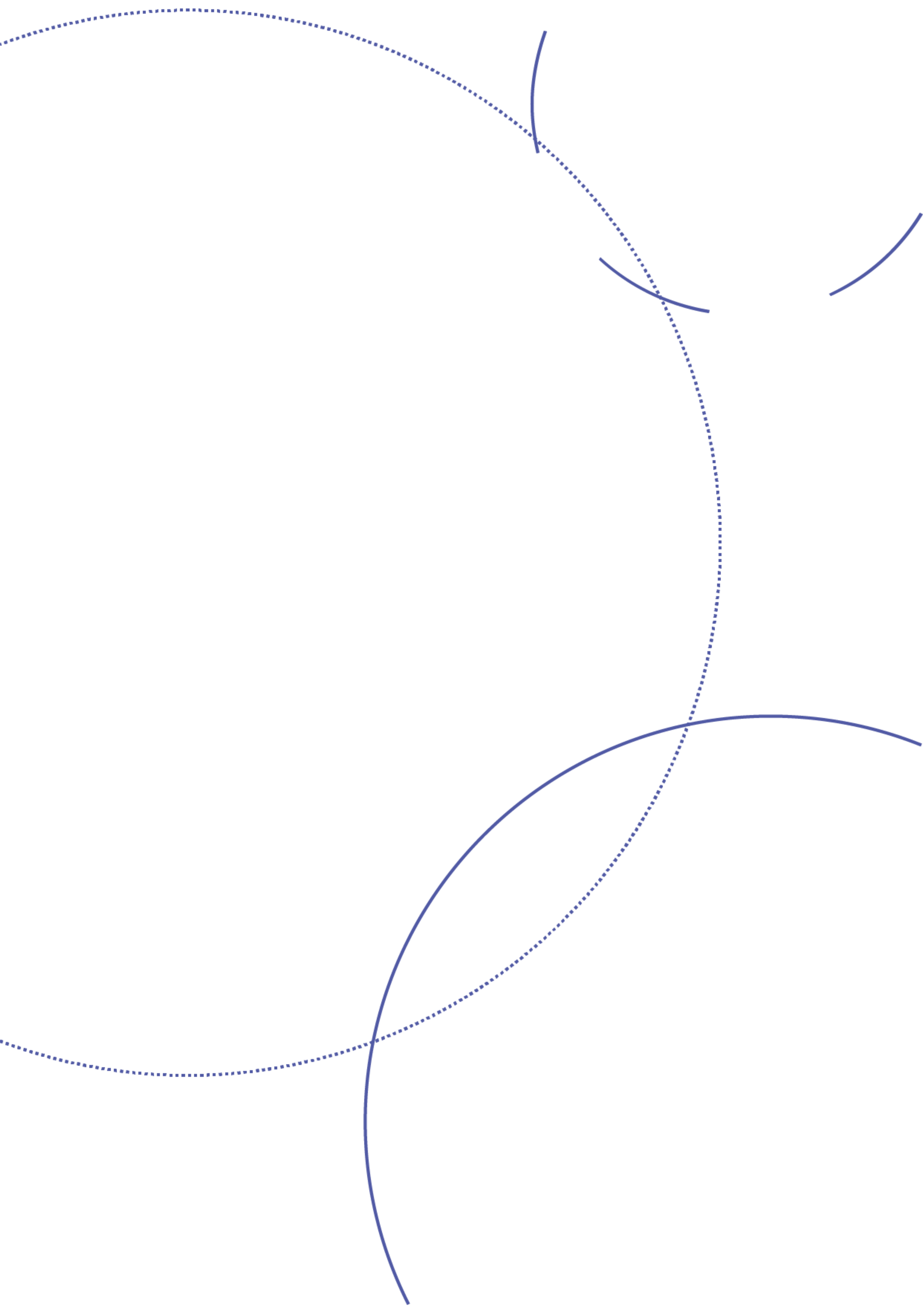
HMICS Custody Inspection Report - Argyll and West Dunbartonshire

October 2024

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND

Improving Policing Across Scotland



HM Inspectorate of Constabulary in Scotland

HM Inspectorate of Constabulary in Scotland (HMICS) is established under the Police and Fire Reform (Scotland) Act 2012 and has wide ranging powers to look into the 'state, effectiveness and efficiency' of both the Police Service of Scotland (Police Scotland) and the Scottish Police Authority (SPA). HMICS has a statutory duty to inquire into the arrangements made by the Chief Constable and the SPA to meet their obligations in terms of best value and continuous improvement. If necessary, it can be directed by Scottish Ministers to inspect anything relating to the SPA or Police Scotland as they consider appropriate.

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

Places of detention, including police custody centres within the UK, are monitored as part of the human rights treaty: 'Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT)'. OPCAT requires that all places of detention are visited regularly by a National Preventive Mechanism (NPM), an independent body or group of bodies which monitor detainee treatment and conditions. HMICS is one of several bodies making up the NPM in the UK.

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

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

Contents

	Page
Our inspection	3
Key findings	6
Recommendations	10
Areas for improvement	13
Context	14
Methodology	17
Outcomes	18

Our inspection

During the course of 2022, HM Inspectorate of Constabulary in Scotland (HMICS) and Healthcare Improvement Scotland (HIS) collaborated on a baseline review of the provision of healthcare services to police custody centres across Scotland. A report outlining our findings and recommendations was published in January 2023.[1] We used learning from the review to develop a framework to inspect healthcare services within police custody, and to devise a methodology for the joint inspection of police custody centres.

On completion of the baseline review, scrutiny partners agreed to undertake two joint custody inspections to further develop inspection methodology. We initially inspected and published reports on the primary custody centres in Lanarkshire and Tayside. We thereafter commenced a programme of joint custody inspections for 2023-24, including custody centres in Dumfries and Galloway, Fife, and Ayrshire. We have since commenced a programme of joint custody centre inspections for 2024-25, and this report is the first of these, carried out at the custody centres in Clydebank and Oban within the Argyll and West Dunbartonshire police division.

The inspection was carried out by HMICS and HIS, the aim of which was to assess the treatment of, and conditions for, individuals detained at the custody centres. We have outlined our findings on the delivery of healthcare at the centres in separate sections in this report. This is because the responsibility for healthcare provision at Clydebank and Oban custody centres is covered by different health boards.

This report provides an analysis of the quality of custody centre operations as well as the provision of healthcare services in the custody centres and consequently makes recommendations for both Police Scotland and the healthcare providers.

While recommendations outlined in this report have specific relevance for Clydebank and Oban custody centres, we recognise that some of these will be equally applicable to other custody centres across Scotland and should be considered in future improvement planning by Police Scotland's Criminal Justice Services Division (CJSD). We consider recommendations 1 and 3 from this report to have such relevance.

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

During this inspection, we found common themes that featured as recommendations and areas for improvement in the aforementioned custody inspection reports. We have referenced these within the body of this report where relevant.

The onsite stage of the inspection took place in May 2024. As part of our inspection, we reviewed the Police Scotland National Custody System (NCS) and examined a representative sample of detainees processed at the custody centres during March 2024. We assessed the physical environment, including the quality of cells, and observed key processes and procedures relevant to police custody operations. We also spoke with people detained at the custody centres and interviewed custody staff and healthcare professionals during our visit.

This report, similar to recent inspection reports on Fife and Ayrshire, highlights our concerns regarding a lack of consistency in the recording of information on NCS. While some aspects of custody centre operations were recorded well, such as hand-over records, the recording of information relating to criminal justice decisions and care plans was found to be lacking. Despite raising this issue on several occasions, we found disparities, in some cases, between the risk assessments undertaken and the corresponding care plans put in place. There was significant use of CCTV monitoring to mitigate risk but without satisfactory recording and a related rationale.

While we found the provision of healthcare services at Clydebank to be generally good, inspectors have made several recommendations for the improvement of healthcare provision at the Oban custody centre.

Police custody has been subject to considerable scrutiny by HMICS since Police Scotland was established. Since 2013, HMICS has published several custody inspection reports, the findings from which can be found on our website.[2] Police Scotland has made progress in implementing previous recommendations and improvement actions in respect of custody services and is actively working to address those that remain outstanding.

[2] Our custody inspection reports are available on our website.

We wish to thank the officers and staff of the Criminal Justice Services Division of Police Scotland, as well as the health boards/HSCPs responsible for healthcare in the centres inspected.

The custody inspection programme is overseen by Ray Jones, Lead Inspector at HIMCS, with support from HMICS Associate Inspectors and HIS inspectors.

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

Key findings

- The Argyll and West Dunbartonshire police division has two primary custody centres. The principal centre is in Clydebank, the second is in Oban. There are other custody centres in the region that have custody staff working daytime hours only and some that are unstaffed, which are opened when required by police officers.

- The rear yards at both custody centres double as parking for operational police vehicles and, in the case of Oban custody centre, Sheriff Court vehicles. Both yards were accessed directly from the public road and there were no notices or signs restricting unauthorised entry although both were well covered by CCTV viewable from the custody office.

- Both yards were bounded by walls and steel gates which were either of insufficient height, or in the case of Oban, in such a state of disrepair as to render them ineffective to prevent unwanted pedestrian access.

- Inspectors noted some longstanding maintenance and repair issues at the centres that had not been addressed effectively. A defect in the roof of a relatively new modular cell extension at Clydebank has resulted in recurrent leaking and frequent closure of up to four cells.

- The staffing structure across the division appears unusual compared to other divisions, and presents challenges for the consistent supervision of staff. This may, in part, be due to the spread of centres across a wide geographical area, however, is also as a result of gaps in supervision arrangements for custody staff in the lesser used centres.

- Inspectors observed booking-in processes at the custody centres. Standard processes were followed well and detainees were dealt with in a professional manner.

- The custody coordinator role, operating daily in the greater Glasgow area to direct police officers to the most appropriate custody centre, was popular with officers and custody staff, and can reduce delays.

- Our review of records on NCS, found that a letter of rights was offered in all cases. Similarly, the offer of access to a solicitor, and to have a reasonably named person informed of detention, were recorded consistently. The completion and recording of Police Interview – Rights of Suspects (PIRoS) was also consistent.

- Of the records examined on NCS, 14 detainees were strip searched. In several of these, there was a lack of consistent and effective recording to outline decision making processes and authorisation to ensure they were necessary and appropriate in all cases.

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

- We found that there was limited quality assurance and audit of key processes taking place at the custody centres. While Cluster Inspectors sampled cases for audit, these were often in very small numbers and therefore not reflective of overall throughput at the centres.

- Handovers were carried out consistently between staff teams at both centres, and were recorded accurately on NCS.

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

- We found detainee property management arrangements at the centres to be in good order.

- The electronic tablets provided to Clydebank and Oban to record cells checks were not being used, with complications relating to technology cited as the cause.

- Detainees we spoke with at Clydebank and Oban, stated that they had been treated very well by officers and custody staff. They said that custody staff had been respectful and made regular enquiries about their wellbeing.

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

- The healthcare service at Clydebank custody centre is nurse-led with support from forensic medical examiners. This is delivered from a central hub at Govan Police Station, where the healthcare team is based. Healthcare at Oban custody centre is provided (in hours) by the local GP practice through a contract with the HSCP. Outwith this, healthcare is provided by the NHS Highland out-of-hours GP service.

- In both custody centres, clinical examinations and assessments were generally carried out in the healthcare room with the door closed unless the custody staff had highlighted this as a safety risk.

- There was a lack of governance and oversight of the provision of healthcare services to the Oban custody centre. While the HSCP had established structures and processes that provided assurance regarding clinical and care governance; these did not include oversight of healthcare within the Oban custody centre. HIS inspectors raised this issue with the HSCP during our inspection and have requested an improvement plan outlining how this issue will be addressed.

- We were told that the healthcare practitioners at Oban faced challenges with the use of Adastra[3] due to IT issues and some staff not being able to access the system. This resulted in most consultations being recorded on paper.

- We found patient records from 2022 to the date of our inspection, stored in a locked cupboard in the Oban custody centre consultation room. We were concerned that these patient records were not stored securely as non-healthcare staff had access to the consultation room and keys for the storage cupboard.

- The healthcare room at the Oban centre required some upgrading, with staining around the skylight area and some damage to the walls, which would limit effective cleaning.

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

- At Oban, the cleaning products used to clean the healthcare room, cells, and custody area did not comply with guidance in the National Infection Prevention Control Manual (NIPCM) guidance. Although personal protective equipment (PPE) was available, it was not stored appropriately. Sharps bins used to dispose of used needles or sharp medical items, were not correctly labelled. Although a clinical bin was available, this was overfilled.

- An automated external defibrillator was available in the staff office at the Oban centre. We were told that other emergency equipment, such as oxygen and emergency medication were transported by the on-call GP. There was no standard operating procedure or policy in place to ensure responsive management of medical emergencies for GPs and custody staff.

- At both Clydebank and Oban custody centres, there was evidence of signposting detainees to community support services and custody staff were knowledgeable about the support available in the community. Referrals could be made by custody staff, healthcare staff and GPs.

- A range of leaflets and posters were displayed in both centres relating to mental health, substance use, health & wellbeing, harm reduction, peer support and family support services available in the community.

- There were clear processes in place at both custody centres to support healthcare staff to communicate with community pharmacies, community mental health teams, and substance use services where required for continuity of care.

Recommendations

Recommendation 1

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

Recommendation 2

Police Scotland should examine the current staffing model and arrangements at Clydebank and Oban custody centres to ensure they are efficient, effective and meet the needs of the service, staff and detainees.

Recommendation 3

Police Scotland should introduce an effective quality assurance and audit process to ensure that expected custody standards are being met.

Recommendation 4

Police Scotland, supported by Glasgow City HSCP, should ensure that used sharps bins awaiting uplift are stored in line with current guidance.

Recommendation 5

Argyll and Bute HSCP must ensure effective governance systems are in place to provide oversight of healthcare delivery within Oban police custody centre.

Recommendation 6

Argyll and Bute HSCP should continue to investigate solutions to the IT and access issues affecting the use of Adastra by GPs.

Recommendation 7

Argyll and Bute HSCP should ensure that any paper patient records are stored securely so that only healthcare staff can access them.

Recommendation 8

Argyll and Bute HSCP should develop a formal induction programme for new GPs, to ensure a consistent approach to the delivery of healthcare in police custody centres.

Recommendation 9

Argyll and Bute HSCP and Police Scotland should ensure that the healthcare environment is maintained to support effective cleaning.

Recommendation 10

Argyll and Bute HSCP should comply with Health Protection Scotland's NIPCM standard infection control precautions to ensure patient and healthcare staff safety.

Recommendation 11

Argyll and Bute HSCP should ensure systems and processes are in place to monitor infection prevention and control practices and take remedial action when areas of improvement are identified.

Recommendation 12

Argyll and Bute HSCP should implement systems and processes to support healthcare and police custody staff in managing medical emergency situations.

Recommendation 13

Argyll and Bute HSCP should review its process for sharing healthcare information on patients with custody staff.

Recommendation 14

Argyll and Bute HSCP must ensure approved processes are in place that are documented and approved through the appropriate governance routes, to support staff with the supply, storage, dispensing, and safe destruction of medicines.

Recommendation 15

Argyll and Bute HSCP should have approved processes in place to support the delivery of consistent evidence-based care including the management of patients withdrawing from alcohol or other substances.

Recommendation 16

Argyll and Bute HSCP should provide detainees with take home Naloxone kits where appropriate and in advance of release.

Recommendation 17

Argyll and Bute HSCP should offer nicotine replacement therapy to detainees who smoke to support their healthcare.

Recommendation 18

Argyll and Bute HSCP should ensure standardised risk assessments are available to all healthcare staff and these are completed consistently where required.

Areas for improvement

Areas for improvement	Number
The custody centres should review internal and external security features and take appropriate steps to mitigate risks.	1
The Oban custody centre should ensure that the automated external defibrillator is situated in an easily identifiable position, with clear signage in place for direction to its location.	2
The Oban custody centre should make safe ceiling lighting fixtures in cells, which in their current state are potentially removable or present a ligature risk.	3
The Oban custody centre should ensure that custody constables have undertaken appropriate training relevant to the role, and have the required level of system access.	4

Context

1. Custody is delivered throughout Scotland by the Police Scotland Criminal Justice Services Division (CJSD). This division is one of several national divisions which sit alongside and support the thirteen local policing divisions. CJSD is led by a Chief Superintendent who reports to an Assistant Chief Constable and in turn, to the Deputy Chief Constable for local policing. Custody is delivered in accordance with the custody standard operating procedure,[4] which is updated and amended regularly to reflect changes in practice guidelines and expectations.

2. Custody throughput has been in steady decline since the implementation of the Criminal Justice (Scotland) Act 2016 (the 2016 Act), and particularly during the Covid-19 pandemic, which placed increased scrutiny on arrests and detention. Throughput volumes have increased in the past two fiscal years, though have not returned to pre-pandemic levels. Argyll and West Dunbartonshire custody centres have seen a seven per cent increase in throughput over the past year, while the national throughput has increased by just over five per cent on the previous year (see tables 1 and 2 below).

Table 1 – National custody throughput

Year	2019-20	2020-21	2021-22	2022-23	2023-24
Throughput	114,815	100,716	97,783	98,964	102,179

[4] Police Scotland, care and welfare of persons in police custody, standard operating procedure – Private item (2022).

Table 2 – Custody centre cell capacity and throughput

Custody centre	Number of cells	2022-23	2023-24
Clydebank	29	5,002	5,323
Oban	7	422	468
Lochgilphead	3	120	106
Dunoon	9	200	206
Campbeltown	8	105	120
Rothesay	5	106	124
Tobermory	1	8	11
Craignure	1	3	9
Tiree	1	4	2
Bowmore	2	17	33
Total	66	5,987	6,402

3. Custody centres in Scotland are organised into clusters, each led by a Cluster Inspector. The custody centres we visited during this inspection, Clydebank and Oban, serve the Sheriffdom areas of Dumbarton, Oban, Dunoon, Rothesay and Campbeltown. Clydebank generally accepts detainees from the Glasgow and Dunbartonshire areas. Detainees from Argyll and Bute, and the islands of Mull, Tiree, Islay and Jura are usually processed at local stations and are either held at these for court or transferred to Oban or Clydebank for operational purposes. All of the custody centres are located within local area police stations.

4. Dunoon and Rothesay are ancillary centres located within the same local policing division (Argyll and West Dunbartonshire) though CJSD aligns them with cluster 8, which includes Renfrewshire and Inverclyde. Ancillary centres are not routinely staffed but can be opened by trained staff as and when required. The ancillary centres were not physically inspected but a proportionate sample of custody records from each were examined remotely.

5. At the time of our inspection, all staff observed the CJSD 222b[5] shift pattern. Each staff team at Clydebank was made up of a police sergeant, a criminal justice police custody and security officer (CJPCSO) team leader, and either three or four CJPCSO staff, as it varies by team. At Oban, teams were made up of a police constable and a CJPCSO. At the time of the inspection, two of the CJPCSO posts were vacant and one constable post was vacant, with recruitment processes being underway.

Independent custody visitors

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

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

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

Methodology

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

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

10. During the inspection, we examined the treatment of, and conditions for, detainees at the centres. We observed key custody processes and assessed the custody environment, condition of cells and facilities for detainees. We undertook interviews with custody staff and managers, as well as healthcare practitioners (HCP) that were present during our visit. We also spoke with people detained in custody at the time.

11. A proportional sample of custody records were examined from those created across all custody centres in the Argyll and West Dunbartonshire police division during March 2024. Of the 563 records for that period, 473 related to people processed at Clydebank. The remainder were spread across the smaller centres. We sampled 10% of the 563 records for review on NCS.

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

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

Outcomes

Custody centre condition and facilities

14. The custody centres at Clydebank and Oban were incorporated into the footprint of existing operational police stations. Clydebank had a single-story layout with a capacity of 29 operational cells. Oban custody centre had a capacity of seven cells spread over two floors and forms part of a police station constructed in 1881, with the existing cells complex added in 1897.

15. We examined the route into both custody centres and found both rear yards doubled as parking areas for operational police vehicles and in the case of Oban, Sheriff Court vehicles. Both yards were accessed directly from the public road and there were no notices or signs restricting unauthorised entry, albeit both approaches were well covered by CCTV, viewable from the custody office. Both yards were bounded by walls, however, in the case of Clydebank, the wall was low and easily scalable.

16. Both yards featured steel gates/barriers. At Oban, the steel barrier was in a state of disrepair and had missing steel bars/panels. The gates would not prevent pedestrian access should it be required and while they could be used to prevent vehicular access, we were told they were rarely closed. Notably, inspectors were informed that officers had, at times, been confronted by aggressive members of the public encroaching on to the insecure rear yard at Clydebank.

17. The limited parking area at the entrance to both custody centres was also used by a variety of operational police vehicles, further restricting accommodation for custody vehicles. The rear yard at Oban also provides rear access to the adjacent Sheriff Court building and consequently has to accommodate pedestrian and vehicular access for that building.

18. Both yards were clean and otherwise free of unnecessary items except for two large steel bars, which were apparently those pieces missing from the Oban gate and had been stored against a wall in the yard. We highlighted these at the time of our inspection.

19. On inspection, there were several security issues relating to the initial access routes to both custody centres, which could present a potential escape risk.

20. Access to Clydebank custody centre was via two initial unsecured doors leading to a small vestibule and main access door secured by a keypad and intercom linked to the custody office. This space led to a further lobby area from which access could be gained through further doors to the detainee access room, custody office, walk-through holding cell leading to the charge bar and a fourth unsecured door. This door opened into the main station stairwell and nearby “push bar” fire escape leading to the unsecured rear yard.

21. In addition, the direct return route from the initial vestibule area to the rear yard was via two poorly secured doors, containing flimsy Perspex panels instead of glass. The magnetic locking mechanism immediately adjacent to these doors was operated by way of an obvious large green button, which could be utilised by any person seeking to exit back into the unsecured yard.

22. Oban presented similar security concerns. The centre was accessed via a locked keypad and intercom-controlled door linked to the office, which led to a corridor from which access can be gained to the cells complex. However, an unsecured door led to a stairwell accessing the wider station and further door leading to the public street, which could be freely opened from the inside. Similar to Clydebank, the direct return route from the corridor to the rear yard could be opened by anyone by way of a simple door handle.

23. The aforementioned security issues were raised with local staff, however, these were acknowledged as being longstanding issues.

24. Given the potential security risks outlined above, we have highlighted the following area for improvement.

Area for improvement 1

The custody centres should review internal and external security features and take appropriate steps to mitigate risks.

25. The holding area at Clydebank, was well-lit with a single bench, affray strip,[6] CCTV cameras and microphones. The room was clean and contained information posters conveying details regarding CCTV recording, disability awareness and available translation facilities.

26. There was no separate detainee holding room at Oban. Instead, the solitary charge bar had a bench directly opposite, which allowed for one escorted detainee to await processing.

27. Both holding spaces were only capable of accommodating one detainee at a time resulting in police vehicles queuing outside during busier periods.

28. The spacious double charge bar in Clydebank and single bar in Oban both contained seated workstations and, in the case of Clydebank, these were divided by solid partitions. However, owing to their shallow depth, offered little in the way of separation between the two processing spaces. The workstations were not elevated, and each were separated from the detainee side by a secure retro-fitted Perspex safety screen.

29. Detainee property storage at both centres was located in rooms monitored by CCTV, which were immediately adjacent to the charge bars. Property was stored in lockable floor mounted steel lockers. Both the processing areas were covered by multiple CCTV cameras, including overhead microphones. We found prisoner property arrangements in both centres to be secure and orderly.

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

30. At both centres, the charge bar/processing areas were spacious and practically situated adjacent to entrances and main staff offices. Each processing area afforded access to additional custody facilities such as well-appointed medical examination rooms, multiple storerooms, photograph/impressions/intoximeter rooms and DNA storage.

31. The detainee interview room, located in the cell corridor at Oban, was not covered by internal CCTV cameras. The room had an affray strip, however, when the door is closed it cannot be opened from the inside and exit can only be achieved by way of an intercom-controlled lock, activated by custody staff. This poses a potential hazard for occupants should a detainee become volatile.

32. In Clydebank there were two detainee access rooms, however the single bespoke interview room was located on the first floor of the station, which meant detainees had to be escorted via two flights of stairs to access this. This cramped room, which contained un-secured furniture, was dimly lit with artificial light and had a small window that didn't close properly leading to noise from the street, which could affect interview recording quality. The room did not have an affray strip, and was not covered by CCTV.

33. Both custody centres had well-appointed kitchens, with Oban's being located outwith the custody footprint and shared with the main station. Both kitchens were spacious, clean and tidy, and contained a variety of appropriate foodstuffs and suitable food hygiene and preparation guidance.

34. The custody centres had clear, suitably located, multilingual posters at charge bars to assist in identifying language translation requirements. The centres also had literature and posters to inform staff of requirements relevant to movement and handling, security and welfare provision and general risk considerations for incoming detainees. There were materials publicising detainee rights and on how to access support services such as "We are with You".[7]

[7] We are with You is a third sector support service for people with drug and alcohol misuse issues.

35. The staff office at Oban was small but suitably provisioned. It contained two workspaces for custody staff, and a third space dedicated for operation of the Local Authority owned CCTV system. At Clydebank, the office was more spacious and also accommodated co-located public counter staff, however, their workstations faced away from the multiple CCTV screens displaying footage from cells and the wider complex.

36. Both offices were tidy, well-lit and well-appointed with wall mounted CCTV screens to monitor cells and other parts of the centres. These were well-situated, adjustable and positioned for good sightlines across the office space.

37. The Clydebank office stored fire safety equipment and first aid materials including automated external defibrillator (AED) devices. In Oban, however, the AED was stored on a shelf in the main staff office and there were no associated signs or posters in the charge bar, or elsewhere in the centre, to highlight its location. This could result in an unnecessary delay should a member of staff be new to the centre or in the event that someone is covering a shift from one of the other centres.

Area for improvement 2

The Oban custody centre should ensure that the automated external defibrillator is situated in an easily identifiable position, with clear signage in place for direction to its location.

38. Whiteboards were clearly visible within the custody offices and were being used for relevant detainee care and welfare notes. Suitable staff rest and refreshment spaces were provided within the wider station footprints.

39. Both centres had dedicated CCTV observation rooms. In Oban, a recently constructed room was located off the main cell corridor in a re-purposed detention cell. It was well-lit and excellently provisioned with two separated screens, comfortable furniture and good ventilation and heating. In Clydebank, the artificially lit facility was located off the main custody office and contained twin separated monitors. Both rooms were equipped with a linked affray strip and had posters providing appropriate guidance for observers relating to detainee risk factors.

40. Custody staff routinely wore appropriate PPE for control and restraint purposes. However, did not routinely carry ligature cutters, albeit these items were available for use at the charge bar and staff offices at both centres.

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

42. Routine fire alarm tests were being carried out weekly. These were recorded and reported via the police SharePoint system and are monitored by the cluster police inspector.

43. Overall, both custody centres were adequately equipped with well-situated and fully functional CCTV cameras linked to the charge bar and staff offices. The majority of wall surfaces within the custody centres, and adjacent rooms, were fitted with multiple affray strips, the activation of which will sound a loud siren audible throughout the custody centre. These were easily accessible and were highly visible illuminated horizontal strips with the exception of some in Oban, which were of older, unlit design. All panels were linked to a central control panel located in the custody offices.

44. In Oban, however, it was noted that the staff side of the charge bar/processing area and adjacent office did not contain affray strips, meaning any incidents on the detainee side of the centre, which required an emergency response, would require officers or staff to use an affray strip in the cell corridor or utilise other means to raise the alarm.

45. The general condition of the custody centres, notwithstanding the aforementioned defects, was good. There was evidence of minor damage to some parts of the building fabric as well as routine maintenance requirements, however these instances had been identified and documented by staff for appropriate remedial action.

Condition of cells

46. The cells complex at Clydebank comprised of 30 cells, with one cell having been re-purposed as a temporary store, leaving 29 cells functioning. Most cells were within the original part of the building, however, 11 cells were located in the adjoining modular extension, which is a more recent addition to the complex.

47. Notably, two cells in the extension were temporarily closed as a consequence of a water leak emanating from the flat roof above. According to staff, this was a recurring issue that frequently reduced capacity by up to four cells at a time. The issue has been subject of longstanding maintenance requests to address the problem, however, the cause of the leak remained unresolved at the time of inspection.

Recommendation 1

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

48. Twenty six cells were inspected at Clydebank, with three cells being closed for essential repairs. The remainder were found to be in generally good physical condition with only minor defects, all of which had been recorded for maintenance follow up.

49. All of Oban's seven operational cells were inspected, which were distributed three on the ground floor and four on the first floor. The first-floor cells are routinely used by GEO-Amey (detainee transport agency), to hold detainees for court as the adjacent Sherrif Court building has no cells of its own.

50. All cells at Oban were lit by way of glass brick windows and ceiling lights, however, although the light switches are dual function, only one light setting is achieved.

51. A potential hazard was also discovered concerning the integrity and placement of the light fittings within cells on the upper floor. Cells on the upper floor had retrofitted internal lights that have been fitted over or next to uneven ceiling features, which in the case of two cells, has resulted in small gaps between the light fixture cowling and the ceiling representing either a ligature risk or a risk of detainee access to a removable and potentially hazardous fixture.

52. This was reported to the custody officer during our inspection and noted in the custody centre maintenance file for immediate attention.

Area for improvement 3

The Oban custody centre should make safe ceiling lighting fixtures in cells, which in their current state are potentially removable or present a ligature risk.

53. All operational cells in both custody centres were equipped with ceiling mounted CCTV, which afforded unobstructed views of the entire cell. The footage from the in cell CCTV is routed to both the custody office and CCTV viewing rooms, where it could be viewed in various configurations on high quality monitoring screens.

54. Cells in both centres contained low plinths able to accommodate the thick mattresses and separate pillows supplied. One cell in Clydebank contained a raised plinth and all cells were lit by dual-mode artificial lighting and natural light from glass brick windows/skylights.

55. The cells in Clydebank were equipped with internal intercom/call buttons linked to the charge bar and staff office. The cell with the raised plinth had two intercoms, one at plinth level and one at the door, which could be beneficial for someone with mobility difficulties. Staff at Oban stated that if a detainee has specific accessibility requirements, consideration is given to conveying them to the most suitable and appropriate custody centre, based on availability, distance and identified needs.

56. The cells in Oban contained toilets with external controlled flush and paper supplied on demand. In Clydebank, the majority of cells featured internal and external controlled flush toilets. The original (older) cells within Clydebank contained internal push button toilet flushes, which although safety compliant when fully functional, can present ligature risks. However, these were subject to frequent checks by custody staff. This was evidenced by a number of said internal flush buttons having been permanently deactivated and sealed.

57. The cells in the modular extension in Clydebank had toilets with an internally controlled flush, as well as anti-ligature compliant automated hand-washing and drying units.

58. Additional washing facilities were available in the cell corridors at both centres. In Clydebank, the cells complex had a shower room located in the extension, however, at time of inspection, the shower only provided cold running water. This was, according to staff, a longstanding and unresolved maintenance issue. The shower cubicle was otherwise clean, ensured modesty and was wheelchair accessible.

59. The cell corridors had appropriately situated sinks at different parts of the centre. The water supply for the sinks was fully functional with hot water on demand.

60. The cells complex at Oban had a shower room located on the lower level that was clean and ensured modesty, however, due to stepped access was not wheelchair accessible. Adjacent to the shower was a double sink with a fully functioning water supply.

61. All cell doors at Clydebank were of contemporary construction with three-position service hatches, vertical peep grille and fitted with slam locks. All cell doors in the Oban custody centre were of older construction, with two-position service hatches, single peep hole and slam locks.

62. Custody staff undertook cell checks every Tuesday, which included a check of the AED equipment. Any issues identified were recorded electronically and also manually on the whiteboard for the attention of the custody supervisor.

63. All cells in both centres were equipped with smoke detectors linked to a VESDA VLS panel.[8]

64. Cleaning at Clydebank and Oban is provided by external contractors, with cleaners attending the centres every morning. If cells are not vacated in time for cleaners, custody staff indicated they will undertake the cleaning duties, despite not having received any formal training in the appropriate use of cleaning chemicals.

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

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

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

Custody centre staffing

66. As previously outlined in this report, the Argyll and West Dunbartonshire police division area has two primary custody centres in Clydebank and Oban. These are staffed on a full-time basis. However, some custody centres in the division are staffed during daytime hours only. These are based in Lochgilphead, Dunoon, Rothesay, and Campbeltown. There are also ancillary custody centres in Tobermory and Craignure on the Isle of Mull; Bowmore on Islay; and Tiree. These facilities are not routinely staffed and are opened as required; operated by custody trained local policing officers.

67. Oban, Lochgilphead, Campbeltown and the islands are supervised remotely by the custody sergeant based at Clydebank. Dunoon and Rothesay are supervised remotely by the custody sergeant based at Greenock, despite Greenock being in a different local authority area and different local policing division (Renfrewshire and Inverclyde).

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

68. Clydebank has a sergeant, a CJPCSO team leader and four CJPCSOs on each team. Oban has a police constable and CJPCSO on each team. Both centres had vacancies at the time of our inspection.

69. While the sergeant at Clydebank provides operational supervision of detainees in custody at the aforementioned centres, they do not line-manage any staff. The team leader at Clydebank is the first-line manager for CJPCSOs at Clydebank and at Greenock, despite this being 25 miles away. As a result, the team leader is seldom able to meet with their staff at Greenock.

70. The team leader based at Lochgilphead is the first-line manager for all CJPCSOs at Campbeltown, Dunoon, Oban, Lochgilphead and Rothesay – this relates to seventeen members of staff. The team leader is seldom able to meet with the staff they manage and does not speak with them regularly.

71. At Clydebank, responsibility for custody centre operations is shared between the sergeant and the team leader. A team leader is never left to manage Clydebank without a sergeant. However, if the team leader is absent, then the sergeant will manage all aspects of custody operations alone, as the team leader post is not backfilled. This is a similar model to that found in the primary custody centres we inspected in Tayside, Fife and Ayrshire.

72. Sergeants are responsible for all criminal justice decisions and their function is specified in legislation. Team leaders line manage CJPCSO staff and are responsible for the care and welfare of detainees, but only once a sergeant has made the initial decision for detention, which introduces split responsibilities. We highlighted the importance of ensuring clarity regarding the role of custody supervisors in our custody inspection report on Tayside, and made the following recommendation:

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

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

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

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

74. The premise of the PC-led model is that suitably trained, experienced and approved police constables, who have the proven capability to perform the duties of custody officer, assume the lead role for co-ordinating onsite custody operations under the remote supervision of a custody sergeant. PC-led centres are limited to a maximum of ten detainees at a time. Responsibility for authorising arrest, liberation, and care and welfare decisions rests with the remote sergeant.

75. The PC-led model operates in Oban custody centre. At Oban, a custody constable can work with an untrained constable or CJPCSO, but a CJPCSO must work with a trained custody constable. Therefore, if local policing cannot provide a trained custody constable, the custody centre cannot be used.

76. While Oban has dedicated custody staff, the centre has limited resilience without seeking local policing backfill. There have been times when a detainee is transferred a considerable distance from Oban to Clydebank and back the following day for court, as a result of insufficient staffing at Oban.

77. In one such instance, a detainee was arrested in Oban on a Friday to be held for court in Oban on Monday. However, they were transferred to Clydebank the next day due to staffing issues at Oban, and then returned for court the following Monday. This equates to a round trip of around 170 miles, on an A class road, in the back of a police van. While we recognise that such instances are not commonplace, efforts should be made to avoid this wherever possible. We also recognise that the absence of operational weekend courts, further contributes to these types of long transfer journeys taking place.

78. It is rare that Clydebank operates as a PC-led custody centre. While the sergeants there accepted that criminal justice decisions could be made remotely, there was concern about the level of risk and responsibility they held. Sergeants we spoke with, highlighted that they were conflicted about being responsible for the welfare of detainees that they had not seen or fully assessed due to remote supervision. When a team leader is absent, sergeants can be very busy at Clydebank as they assume the wider responsibilities outlined above. However, they are also required to remotely supervise several PC-led and ancillary centres simultaneously, which can present considerable challenges.

79. While we recognise that delivering an effective custody service in such a diverse landscape will come with challenges, it is anticipated that custody staff receive adequate supervision, and that the model meets the needs of detainees as well as the staff and custody centres involved.

Recommendation 2

Police Scotland should examine the current staffing model and arrangements at Clydebank and Oban custody centres to ensure they are efficient, effective and meet the needs of the service, staff and detainees.

Arrival at custody and booking-in process

80. Inspectors observed five detainees being booked in to custody; three at Clydebank and two at Oban. In all instances, staff were thorough and professional. They built a good rapport with detainees and were respectful. We noted that custody staff received advance notification of detainee particulars from arresting officers, either by telephone or radio, to enable the commencement of background checks. Custody staff at Clydebank checked CHS, PNC, the national custody system and iVPD,[10] prior to the arrival of arresting officers.

81. At Oban, the custody constable on duty had not completed the necessary training to undertake checks on CHS and PNC systems. The officer had to telephone Clydebank to obtain background information, which can cause unnecessary delays. We were advised this was also the case for other custody constables based at the centre.

Area for improvement 4

The Oban custody centre should ensure that custody constables have undertaken appropriate training relevant to the role, and have the required level of system access.

82. Custody centres in the greater Glasgow area, have benefitted from the services of a custody co-ordinator for several years. Operating between 1600 hours and 0200 hours every day, a CJPCSO based at London Road police station in Glasgow, monitors the radio for the greater Glasgow area, which includes Clydebank. When officers arrest a person, they call the co-ordinator to explain where they are, who they have arrested and for what offence. The co-ordinator will inform the officers which custody centre they should attend. Consideration is given to the proximity of custody centres and to where there may be large queues, which may justify diverting officers to alternative custody centres. The model has been introduced to provide the swiftest custody service possible for officers and reduce transport time for detainees where possible.

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

83. Our review of records on NCS found that the average waiting time relevant to the booking-in process at Clydebank and Oban, was in excess of the national custody average. It should be noted that this was in part influenced by around ten records from our sample that, for a variety of reasons, took considerably longer to process.

84. In some of these instances, the wait time was unavoidable. For example, where an individual had been arrested in England on a Scottish warrant. In one such case, the record was created retrospectively, which accounted for a three hour delay in authorisation.

85. However, more importantly, we saw instances where the authorisation time had been affected as a result of custody staff at the ancillary centres experiencing delays in accessing a sergeant for authorisation.

86. In one case, we found a ninety-minute delay for the authorisation of an arrest at Rothesay, where contact must be made with the custody sergeant at Greenock for authorisation. In another, there was a delay of almost two hours in the case of an arrest in Dunoon. On that occasion, the authorisation was obtained from a sergeant based at Govan; evidently as a result of staff being unable to obtain authorisation from Greenock.

87. There can also be an added delay in obtaining authorisations at ancillary centres as sergeants must, quite rightly, satisfy themselves that the arrest is necessary and proportionate, which involves a detailed discussion of the circumstances and available evidence on the phone. This can take more time than if it was a face-to-face situation. The longest waits occurred at ancillary centres, however, there were several examples where the authorisation time was also very swift.

88. When an arrested person is brought to a police station they should always be searched. Often this search is limited to clothing and pockets, known as a standard search, but there are occasions where it is appropriate that the search involves the removal of the detainees clothing. Strip searches should be conducted in as dignified manner as possible and must be authorised by a sergeant based on risk, necessity, and proportionality. The searches we witnessed were safe, methodical, and respectful with officers routinely using handheld metal detectors and ‘Ampel’ probes (large tweezers), which were stored at the charge bar.

89. Of the records we examined, a quarter of the detainees in the sample were strip searched. While most of the records contained appropriate authorisation, this was not always the case. In one case, there was no record of authorisation by a sergeant. In another, there was no rationale recorded for the strip search and in two further cases, the rationale was limited to a comment on previous or historical drug use.

90. We consider that if it is necessary and proportionate for a detainee to undergo a strip search there should be a suitable rationale recorded that provides clear grounds, and each instance should be appropriately authorised. We would question if historical drug offending alone, amounts to sufficient grounds to strip search a person on each occasion they are arrested, particularly when the drug related offence may have been years earlier. None of the detainees reviewed in our sample of records had been the subject of an intimate search. We understand that such searches are very rare and, when undertaken, are conducted on medical grounds and by a medical professional.

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

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

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

Legal rights

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

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

94. As previously indicated, there are times when detainees spend long periods in custody as a result of being held for court over a weekend. The average time spent in police custody from our sample of records was almost 23 hours. This figure included eight records where the period of detention exceeded two days, each relating to a detainee waiting over a weekend to appear at court. However, it should be noted that the sample of 56 records does not accurately reflect typical average detention times. This is reflected more fully when considering the whole month that the sample was drawn from. This indicates that the majority of detainees (66%), spent under 12 hours in custody and an additional 20%, were detained for under 24 hours.

95. Police custody centres are generally not equipped to provide satisfactory accommodation for several days of detention. Detainees often present with high-risk health, addiction and mental health needs and tend to be in crisis or distress. As in the case of Clydebank and Oban custody centres, there is no continuous on-site medical service and outdoor exercise is not available.

96. Were custody courts in a position to sit during weekends, this would have the potential to impact positively on the wellbeing of detainees subject to extended periods of police detention. While this would require a significant change in practice for criminal justice organisations including Scottish Courts and Tribunal Service, COPFS, GEOAmey and other partners, it would spread demand more evenly. As well as improved outcomes for detainees, there would be benefits to Police Scotland and partners by reducing the disproportionate weekend spike in demand for cell capacity.

97. There were notes recorded in the majority of records to show that a handover between shifts had been conducted. During handovers between custody supervisors and other staff, supervisors are required to review the criminal justice decision and care plan, and satisfy themselves that the existing measures remain appropriate. The consistency and quality of handover records was notable and is considered good practice.

Risk assessment and care plans

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

99. This initial risk assessment process allows custody staff to determine a bespoke care plan for detainees and involves determining whether the person presents high or low risk and applying a corresponding level to determine the appropriate frequency of wellbeing observations. This approach is based on an assessment of threat, risk and vulnerability. Responses to the vulnerability questionnaire and the subsequent care plan should be recorded on NCS. Based on the outcome of the risk assessment, detainees are subject to observations and rousing[11] in accordance with the following standardised scale:

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

100. As previously indicated, we sampled 56 of 563 records relevant to throughput in March 2024. Of these, there were eight records for a younger child (aged 15 and under) and fifteen records for older children (16-17), and we sampled three and two of these respectively. This reflects that relatively few children were brought to custody during the period examined. The following statistics are therefore largely based on adults in custody.

[11] 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.

101. We found that 30% of detainees were intoxicated on arrival at custody; 11% declared they were alcoholics and 20% were drug dependent. Almost 57% disclosed a mental health condition and 48% reported they had previously self-harmed or had attempted suicide. Almost half were on prescribed medication, and 9% stated they had difficulty with reading and writing. The vast majority (91%), had some form of criminal or police information record.

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

103. The vulnerability risk assessment of 27 detainees was assessed as high and 29 were deemed to be low. In each instance, there was a comment on NCS to explain why a high risk decision was made. There were a variety of reasons recorded, which included current and historical mental health conditions, medical conditions, intoxication levels, the need for prescribed medicines and presentation.

104. While 27 detainees were assessed as high risk, 11 of these were placed on standard, level 1, 60-minute observations. This is similar to the ratio we found in our inspection of Ayrshire custody centres, which was also 41%.

105. The issue of incongruence between risk assessments and the corresponding observation levels applied, has been highlighted in previous custody inspection reports, and has been the subject of recommendations made in our reports on Fife and Ayrshire custody centres. We consider these to have clear relevance for the custody centres in Clydebank and Oban, and while we anticipate this concern will be addressed, we do not intend to make an additional recommendation in this regard.

Detainee care

106. We interviewed three detainees during our inspection, two at Clydebank and one at Oban. All provided complimentary feedback about custody staff and the arresting officers. They had been provided with their rights and stated that custody staff had been respectful and made regular enquiries about their wellbeing.

107. The recording of cell visits by custody staff, indicated that these had been punctual and carried out appropriately. We noted, however, that staff practice was to conduct observations and note the time and response on a piece of paper before returning to the office to update the details onto NCS. Both custody centres have been provided with hand-held electronic tablets to carry out this task, however these were not being used.

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

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

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

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

    We consider these recommendations to have relevance for practice across all custody centres. We anticipate that Police Scotland will implement any practical adjustments necessary to ensure that staff comply with the requirement to use the ICT systems provided to them to enhance the safety of people in custody.

109. Almost all detainees were provided with food and drink as required, and any remaining individuals for whom this was not recorded, had been released within a short period, with no necessity to provide food. Detainees were typically offered a wash in the morning prior to attending court. Those being released to return home were not generally offered a wash or shower, although where requested, this was largely accommodated.

110. All detainees are asked if they would like to be referred to a third sector agency to provide them with support on issues such as addiction, mental health, or if they formerly served in HM armed services. The availability of support services differs from area to area, however, NCS has a compulsory field that staff must update to indicate if the offer was accepted, declined or if was not appropriate. The offer of a referral to a third sector agency was made and declined in 35 cases within our sample.It was considered as being not appropriate in the remaining cases, although in eight of these, there was evidence of substance use and mental health issues, which suggested that a referral may have been appropriate.

111. Strip searches at the centres take place within the detainees cell. There are no cells or custody areas that are not covered by CCTV, and cameras are not turned off during a search. This process is commonplace across most custody centres. While the viewing of CCTV is restricted, as monitors are either switched off or covered during a search to prevent staff not involved in the search from viewing it, detainees should be made aware of this arrangement.

Audit of custody records

112. Current practice at the custody centres, is that only four custody records are dip sampled each month for audit and quality assurance purposes. Given that there were 563 records for March 2024, four records represent a very small proportion of these. It is appreciated that where an adverse incident occurs, managers may direct an audit to be carried out in addition to these. However, we consider that the absence of a more comprehensive audit regime could allow poor practice and inconsistency to become established. Good record keeping encourages good compliance with policy, which provides greater confidence that the criminal justice ends are met, while meeting the care and welfare needs of the detainee.

113. This issue has been highlighted in recent inspection reports, and a recommendation was made in our report on the inspection of custody centres in Greater Glasgow in June 2019. **Recommendation 5** from that report states that:

"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."

This had previously been addressed by Police Scotland through the introduction of dedicated quality assurance roles and processes, however, this has diminished over time. We consider that Police Scotland should revisit how they carry out quality assurance and audit practices to ensure that required standards are met.

Recommendation 3

Police Scotland should introduce an effective quality assurance and audit process to ensure that expected custody standards are being met.

Staff training

114. All custody supervisors have completed two mandatory custody related courses lasting a total of five days. This includes a custody officer induction course, lasting three days, and two days NCS training. They are also trained in first aid, officer safety, fire safety, food hygiene and data protection. Some staff, including all constables at Oban, were not trained in CHS and PNC, which added pressure to other staff to carry out important antecedent checks. This training is hosted at the police training centre at Jackton in East Kilbride, and is a residential course. It was intimated that officers at Oban could not be spared to attend a course.

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

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

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

116. Inspectors were informed that all custody sergeants and constables had received training to administer Naloxone.[12] This was delivered via an online Moodle package and reflects a positive development in terms of the expansion of staff awareness raising and training on this subject. We saw that Naloxone was available for use in the custody centres and, under the current operating model, a sergeant or constable is always available at the centres.

117. As noted previously, the responsibility for healthcare services at Clydebank and Oban custody centres lies with two different NHS boards/HSCPs. We found variations in the model of provision and in the quality of services at the centres, and in order to make a clear distinction between these, we have outlined our findings in the following separate sections of this report.

Healthcare provision at Clydebank

Governance of Healthcare

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

119. The service operates a peripatetic unscheduled care model 24/7 and 365 days a year. The main hub for the healthcare team is based at Govan police station in Glasgow. The nursing team has a combination of registered Adult Health Nurses and Mental Health Nurses. The service aimed to have a minimum of one mental health nurse on duty at any point. The FMEs were provided through a contracted service. The service had recently completed a workforce review that recommended the introduction of Advanced Nurse Practitioners and Healthcare Support Workers. At the time of the inspection, there were no nursing vacancies, although we were told retention of staff could be challenging. The service hoped that the workforce review would support career progression and therefore help with the challenges of retaining staff.

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

120. Healthcare was well managed, with the HSCP providing a clear management structure, as well as monitoring and oversight through its clinical and care governance processes. Regular governance meetings and multiagency meetings took place between NHS staff and Police Scotland.

121. An induction programme for all new healthcare staff was available and staff we spoke with were positive about their induction experience. Training records showed good compliance with mandatory and role specific training, which included equality and human rights, the Istanbul Protocol and trauma informed practice.

122. Clinical supervision was available and was carried out monthly by the senior charge nurse. We were told that some staff had completed NES[13] clinical supervision training and could deliver peer supervision if required. The FMEs held peer review meetings where complex cases were discussed.

123. There was information displayed around the centre on how detainees could make a complaint or give feedback. At the time of inspection, there had been no complaints received in the previous 12 months. The DATIX[14] system was used to report incidents. These were discussed at clinical governance meetings and feedback from incidents was disseminated to staff to support learning.

124. The treatment room was visibly clean and in a good state of repair. Healthcare staff told us they were responsible for cleaning the surfaces in the treatment room. Cleaning of the floors was the responsibility of an external cleaning company. An appropriate chlorine-based cleaning product was available to clean sanitary fittings in line with current guidance. Cleaning of the cells and custody area, including the management of blood or body fluid spillages, was completed by an external company.

125. Care equipment was visibly clean and in good condition. Healthcare staff told us that it was cleaned daily and between patient use. Hand hygiene facilities were available. Personal protective equipment (PPE) was also available and appropriately stored.

[13] NHS Education for Scotland.
[14] Datix system is an online system for all healthcare staff to report any incidents and risks.

126. Sharps bins, which are used to dispose of used sharps, were correctly labelled and had temporary closures in place. Clinical waste was disposed of in line with guidance. The local hospital holds the contract for the collection of clinical waste and sharps bins. Inspectors saw that clinical waste was stored securely in a locked area, however, used sharps bins were stored in an unlocked cupboard.

127. Linen used in the custody area was managed by custody staff and was laundered by an external company. The used linen was stored securely to await collection. No linen was used by healthcare staff.

128. There was an identified infection prevention control (IPC) lead for the custody centre and a programme in place to carry out IPC audits. Inspectors were advised that appropriate policies and the NIPCM was available on the staff intranet. Training records showed that all healthcare staff had completed IPC training.

129. Emergency equipment which included oxygen, suction machine and automated external defibrillators were available and inspectors saw evidence of weekly checks being competed. Emergency medications were also available and in date. Systems and processes were in place for the management of emergency situations, including minor injuries. Training records showed that all healthcare staff had completed Basic Life Support (BLS) training.

Recommendation 4

Police Scotland, supported by Glasgow City HSCP, should ensure that used sharps bins awaiting uplift are stored in line with current guidance.

Access to healthcare

130. Patient healthcare needs were identified through a vulnerability questionnaire completed by custody staff when people were brought into custody. The information given by the detainee may result in a referral being made to healthcare staff.

131. There is no nationally agreed waiting time standard for healthcare assessment of individuals detained in police custody centres across Scotland. However, referrals made from custody centres to healthcare are triaged and seen as soon as possible. Waiting times can vary depending on the number of people in custody, the nature of the assessment and the number of nurses on duty. The current national electronic system for recording healthcare data across all custody centres in Scotland (Adastra)[15] does not provide sufficient functionality to enable clinical data to be appropriately recorded, monitored and reported. As a result, reliable data for patient waiting times for access to healthcare are not available. Detainees we spoke with told us they were happy with the time they had to wait to see the nurse.

132. Detainees could also request to see healthcare staff at any point. Healthcare and custody staff told us these requests would always be facilitated. Information regarding healthcare was included in the booklet ‘Your rights when you are at the police station’. This was in an easy-read format and was routinely given to detainees. We consider this to be good practice. Healthcare and police custody staff could access interpretation services to support patients with the vulnerability assessment and ongoing healthcare assessments. Language identification posters were visible in the charge bar area of the custody centre.

133. Inspectors were told that clinical examinations and assessments were generally carried out in the healthcare room with the door closed to maintain confidentiality, unless custody staff had highlighted this as a safety risk. Following our inspection, we were advised that CJSD were collaborating with healthcare partners to include an additional section in the police custody standard operating procedure to address this issue and clarify expectations. We will continue to monitor this on future custody inspections.

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

134. Custody staff use NCS to record information relevant to detainees, whereas NHS staff use Adastra. The separate electronic systems used by custody staff and NHS staff to record custody data were unable to connect with each other to share information. Healthcare related recommendations were emailed to the custody sergeant who copied the information onto NCS.

135. We viewed a standardised assessment tool used to record assessments, which included the patient’s history, details of examination, assessment and recommendations.

136. Staff were aware of the process for identification and documentation of injuries allegedly sustained as a result of force. Any detainee requests for specific healthcare staff to carry out health assessments could be facilitated.

137. There were no accessible cells at Clydebank’s custody centre. However, where an accessible cell was required, the detainee would be transferred to another police station with an appropriate facility.

Medicines management

138. The healthcare service had a number of policies and standard operating procedures to support staff with the supply, storage, dispensing and safe destruction of medicines. This included ‘The Safe and Secure Handling of Medicines in NHSGGC Police Custody Health Care policy’. The pharmacist was responsible for supporting the governance of medicines management in the custody centre.

139. Medicines, including controlled drugs, were stored securely in locked cabinets in the treatment room. The keys for the medicine cabinets were normally kept in a key safe, which only healthcare staff could access, however this was broken at the time of the inspection. We were assured that the repair of the key safe was being progressed. A safe interim measure was in place.

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

141. Controlled drug registers were completed well with no gaps or scoring through. There was evidence of stock and balance checks being completed. We were told that a range of medicine management audits were completed. We consider this to be good practice.

142. Processes were in place for medications to be administered by custody staff from compliance aids, apart from OST, which was administered by healthcare staff. Custody staff received written information from the Health Care Practitioners (HCP) and the FME to support safe medicine administration. The compliance aids were held securely by custody staff until they were required. The NCS alerted custody staff when medications were to be administered. We checked several stock medications and these were in date with evidence of appropriate stock management.

143. Patient Group Directions (PGD)[16] were in place for the management of alcohol and substance withdrawal and nicotine replacement.

Substance use

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

145. Processes were in place for confirming, collecting and administering community prescriptions for patients within custody who were prescribed OST. For patients appearing in court, OST was not routinely given prior to attending. However, we were told detainees were consistently leaving for court early in the morning and communication systems were in place for OST to be administered to patients upon release through community pharmacy services, to ensure continuity of OST.

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[16] The legal definition of a patient group direction (PGD) is 'a written instruction for the supply and/or administration of a licensed medicine or medicines in an identified clinical situation, signed by a registered professional'.

146. The Scottish Government's Medication Assisted Treatment (MAT) standards came into force in April 2022. These are evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. An initial baseline exercise was undertaken to identify where developments can be made towards implementing MAT, with changes to be put in place once a national agreement is made about what is required within police custody settings.

147. Data recorded showed a range of harm reduction information and interventions were available to detainees in Clydebank with good uptake. Blood borne virus[17] testing was available to all detainees accessing healthcare in custody. All healthcare professionals had access to Naloxone and were trained to administer it. Inspectors were told police sergeants and custody constables were trained and carried Naloxone, therefore there would always be someone available to deliver Naloxone when necessary. Take home Naloxone kits were also available to detainees.

Mental health

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

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

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

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

151. While Registered Mental Health Nurses generally respond to referrals for patients requiring mental health assessments, Registered General Nurses also saw patients at the centre. Training opportunities were available to ensure staff competencies including access to mental health first aid, skills training in self-harm, suicide intervention and prevention. This was good practice.

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

153. Detainees with learning disabilities could be identified from the vulnerability questionnaire and through screening the vulnerable persons database. Systems were in place to involve an appropriate adult service if required.

Pre-release pathways and referrals

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

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

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

Healthcare provision at Oban

Governance of healthcare

157. Custody healthcare is delegated to the Integration Joint Board of Argyll & Bute HSCP by NHS Highland. The HSCP is responsible for the delivery of custody healthcare in Argyll and Bute, which includes Oban police custody centre. The service is provided in hours by the local GP practice through a contract with the HSCP. Healthcare out of hours is provided by the NHS Highland out of hours GP service

158. The HSCP had established structures and processes in place that provided assurance of clinical and care governance; however, these did not include oversight of healthcare within Oban police custody centre. There were no meetings held between the HSCP and Police Scotland to discuss police custody healthcare.

Recommendation 5

Argyll and Bute HSCP must ensure effective governance systems are in place to provide oversight of healthcare delivery within Oban police custody centre.

159. Inspectors from HIS wrote to the HSCP to raise concerns regarding the lack of governance and oversight and requested a formal update on the improvement actions that would be taken. We will follow up on these actions at a future date. The HSCP have recognised the risks associated with the lack of oversight of police custody healthcare, and a draft service improvement plan and associated action plan has been developed to address this.

160. We were told that the service faced challenges with the use of Adastra due to IT issues and some staff gaining access; this resulted in most consultations being recorded on paper.

Recommendation 6

Argyll and Bute HSCP should continue to investigate solutions to the IT and access issues affecting the use of Adastra by GPs.

161. We found patient records from 2022, and up to the date of our inspection, stored in a locked cupboard in the consultation room. We were concerned that these patient records were not stored securely as non-healthcare staff had access to the consultation room and the keys for this cupboard.

Recommendation 7

Argyll and Bute HSCP should ensure that any paper patient records are stored securely so that only healthcare staff can access them.

162. There was no formal induction programme for GPs new to the service. However, we were told that new or locum doctors had the opportunity to shadow an experienced GP. We saw evidence that GPs had attended training and found details of training that had been delivered. We also saw evidence of GPs being signposted to updates from the National Police Care Network.

Recommendation 8

Argyll and Bute HSCP should develop a formal induction programme for new GPs, to ensure a consistent approach to the delivery of healthcare in police custody centres.

163. Complaint advice posters were seen at the charge bar and in the consultation room. We were told that complaints would be managed through the established HSCP complaints process. The service was not aware of any complaints being received about police custody healthcare in the past three years.

164. The DATIX system was used to report incidents. Those reported relating to police custody healthcare or the out of hours service were managed by the area manager in the first instance.

165. The healthcare room at the centre required some upgrading, with staining around the skylight area and some damage to the walls, which would impact on effective cleaning.

Recommendation 9

Argyll and Bute HSCP and Police Scotland should ensure that the healthcare environment is maintained to support effective cleaning.

166. Cleaning the healthcare room, cells, and custody area, including the management of blood or body fluids, was completed by an external company. However, cleaning products used were not in line with the National Infection Prevention Control Manual (NIPCM) guidance. Although PPE was available, it was not stored appropriately. Hand hygiene facilities were available.

167. Sharps bins used to dispose of used needles or sharp medical items, were not correctly labelled nor had the required temporary closures in place. Although a clinical bin was available, this was overfilled, and the lid was seen lying on the floor. There was no care equipment in the healthcare room and the GPs brought their own equipment when requested to carry out assessments on patients.

Recommendation 10

Argyll and Bute HSCP should comply with Health Protection Scotland's NIPCM standard infection control precautions to ensure patient and healthcare staff safety.

168. The linen used in the custody area was managed by custody staff and laundered by an external company. The used linen was stored securely to await collection. No linen was used by healthcare staff.

169. We were told the custody centre had no infection prevention control (IPC) lead or a programme in place to carry out IPC audits. Staff were not aware of any external IPC inspections having taken place to provide assurance.

Recommendation 11

Argyll and Bute HSCP should ensure systems and processes are in place to monitor infection prevention and control practices and take remedial action when areas of improvement are identified.

170. An automated external defibrillator was available in the custody staff office, and we were told that custody staff regularly checked this. We were told that other emergency equipment, such as oxygen, and emergency medications were transported by the GP. No standard operating procedure or policy was in place to ensure responsive management of medical emergencies for both GPs and custody staff.

Recommendation 12

Argyll and Bute HSCP should implement systems and processes to support healthcare and police custody staff in managing emergency situations.

Access to healthcare

171. Patient healthcare needs were identified through a vulnerability questionnaire completed by custody staff when people were brought into custody. The information given by the detainee when completing the vulnerability questionnaire may result in a referral to healthcare staff.

172. Custody staff told us that they generally found healthcare staff responded quickly to their requests for healthcare reviews.

173. Detainees could also request to see the GP at any point. GPs and custody staff told us these requests would always be facilitated. Information regarding healthcare was included in the booklet 'Your rights when you are at the police station'. This was in an easy-to-read format and was routinely given to detainees with reading, writing and language difficulties. This was considered good practice. GPs and police custody staff could access interpretation services to support patients with vulnerability assessment and ongoing healthcare assessments. Language identification posters were visible in the charge bar area of the custody centre.

174. We were told that clinical examinations and assessments were generally carried out in the healthcare room with the door closed to maintain confidentiality, unless the custody staff had highlighted a safety risk. As previously noted, we were subsequently advised that CJSD were collaborating with healthcare partners to include an additional section in the police custody standard operating procedure to address this issue and clarify expectations. We will continue to monitor this on future custody inspections.

175. Custody staff use NCS to record custody information relevant to detainees, whereas NHS staff use summary care plan custody and forensic medical examination paperwork. Therefore, recommendations and information relating to medications following a patient's assessment were given verbally to custody staff; this information was then transcribed onto NCS. A more robust system should be introduced to reduce the risk of healthcare information being missed or recorded incorrectly.

Recommendation 13

Argyll and Bute HSCP should review its process for sharing healthcare information on patients with custody staff.

176. Once the summary care plan was completed by the GP, it was filed in a locked cabinet in the healthcare room. We viewed a standard summary care plan used to record assessments, which included the patient's history, details of examination, assessments and recommendations.

177. Staff were aware of the process to identify and document injuries allegedly sustained as a result of force. Any detainee requests for specific healthcare staff to carry out health assessments could be facilitated.

178. There were no accessible cells at Oban custody centre. However, where an accessible cell was required, the detainee would be transferred to another police station that had appropriate facilities.

Medicines management

179. The healthcare service had no policies or SOP in place to support staff with the supply, storage, dispensing, and safe destruction of medicines. We were told that there was a pharmacist within the HSCP who was responsible for supporting the governance of medicines management in the police custody centres. The HSCP had identified medicine management and governance as areas for improvement in their draft service improvement plan.

Recommendation 14

Argyll and Bute HSCP must ensure approved processes are in place that are documented and approved through the appropriate governance routes, to support staff with the supply, storage, dispensing, and safe destruction of medicines.

180. The only medications held in stock at the custody centre were paracetamol and inhalers, which were stored in a locked cupboard behind the charge bar.

181. Medications were prescribed by the GPs. Various methods were used to ensure robust medication reconciliation, including checking electronic records and speaking with the patient's local pharmacist. This ensured that patients received their regular medication while detained, including any OST. Systems and processes were in place to obtain a patient’s OST from their home address or community pharmacy where required.

182. From speaking with custody and healthcare staff, we were told that more than one dose of a patient's methadone was rarely collected from the community pharmacy at a time. However, if this did happen, doses not immediately administered would be stored in a controlled drugs cupboard at the local hospital, specifically for out-of-hours GPs, and recorded in the hospital register. Single doses obtained were administered by the GP when received.

183. Processes were in place for medications to be administered by custody staff from compliance aids. Custody staff received written information from the GP to support safe medicine administration. The compliance aids were held securely by custody staff until required. The NCS alerted custody staff when medications were to be administered.

Substance use

184. The vulnerability questionnaire used by custody staff included questions regarding the use of alcohol or substances and whether detainees had substance dependency. GPs assessed detainees who appeared to be under the influence or withdrawing from alcohol or substances. They had access to the appropriate tools for monitoring levels of intoxication and withdrawals, carrying out physical observations and prescribing detoxification medication where required. However, there was inconsistency in the documentation regarding the use of tools to monitor withdrawal and no clear process to manage this for custody staff. For example, we saw some GP recommendations included the prescribing of medication for withdrawals for patients on an 'as required' basis. This relied on custody staff making clinical decisions.

Recommendation 15

Argyll and Bute HSCP should have approved processes in place to support the delivery of consistent evidence-based care including the management of patients withdrawing from alcohol or other substances.

185. For patients appearing in court, OST was not routinely given prior to attending. However, we were told that access to OST upon the patient's release was through community pharmacy services.

186. A previously noted, the Scottish Government's MAT standards came into force in April 2022. We saw evidence of an implementation plan and were told that the HSCP were focusing on MAT standard 7 in custody: 'All people have the option of MAT shared with Primary Care'.

187. Blood borne virus testing was not available to detainees accessing healthcare in custody. However, we were told that patients would be signposted to appropriate services, including those offered within the local GP practice.

188. All police custody staff had access to Naloxone and were trained to administer it. Take home Naloxone kits were not available to detainees. Custody staff told us of signposting to drug and alcohol services when detainees are released included: the 'We Are with You' service, and Narcotics and Alcohol Anonymous.

Recommendation 16

Argyll and Bute HSCP should provide detainees with take home Naloxone kits where appropriate and in advance of release.

189. The core team of GPs who attended the custody centre were also practitioners within the drug service in Oban. They could also refer directly to the alcohol service. We were told that the GPs deliver Alcohol Brief Interventions (ABIs) to detainees in custody. However, this was not recorded in the summary care plans and therefore no data is kept regarding the delivery of this intervention.

190. There was no process in place for detainees to access nicotine replacement therapy while in custody.

Recommendation 17

Argyll and Bute HSCP should offer nicotine replacement therapy to detainees who smoke to support their healthcare.

Mental health

191. Custody staff at Oban could request GPs to undertake fitness for court, release, and detention assessments. The recommendations from these assessments were shared with custody staff and included the need for enhanced monitoring or the level of observation required where there was a concern for a patient's wellbeing.

192. Ongoing risk was managed, and changes or concerns were highlighted to the GPs when required by custody staff, who stated that healthcare staff were very responsive and reviewed detainees timeously. We were told not all GPs had access to the standardised risk assessments available on Adastra, therefore standardised risk assessment were not consistently used to record patients' risk of self-harm or suicide.

Recommendation 18

Argyll and Bute HSCP should ensure standardised risk assessments are available to all healthcare staff and these are completed consistently where required.

193. Processes were in place where required for transfer to hospital following an assessment of the patient's mental health needs. We were told this process was well established and transfers could be arranged where required without issue. GPs highlighted challenges when trying to access forensic mental health services for those detainees who require care and treatment on release from custody.

194. We were told that patients could be referred to the distress brief intervention service, which could respond quickly to detainees upon their release from custody.

195. Detainees with learning disabilities could be identified from the vulnerability questionnaire and through screening the vulnerable persons database. Systems were in place to involve an appropriate adult service if required.

196. We were told that the custody centre was rarely used as a place of safety under section 297 and 298 of the Mental Health (Care and Treatment) (Scotland) Act 2003. There was a designated place of safety within Lorn and the Islands Hospital used to support these patients.

Pre-release pathways and referrals

197. We found evidence of signposting detainees to community support services by GP's and custody staff. A range of posters were displayed for services and support available in the community.

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

Detainee transfers

199. We were told that healthcare staff communicate any relevant health information or concerns to custody staff completing the PER form, such as medical conditions or medication. This information is also reiterated in an email sent to GEOAmey. The PER forms were examined at both centres and found to be completed to a good standard.

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

Local policing

201. Inspectors spoke with a number of local policing officers regarding their experience of custody services at both centres.

202. Several officers stated the introduction of custody coordinators had been a significant improvement and has reduced waiting times from what could, at times, be up to 90 mins to what is now, at the very most, closer to 25 minutes during busier times. We regard this as being a welcome development.

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