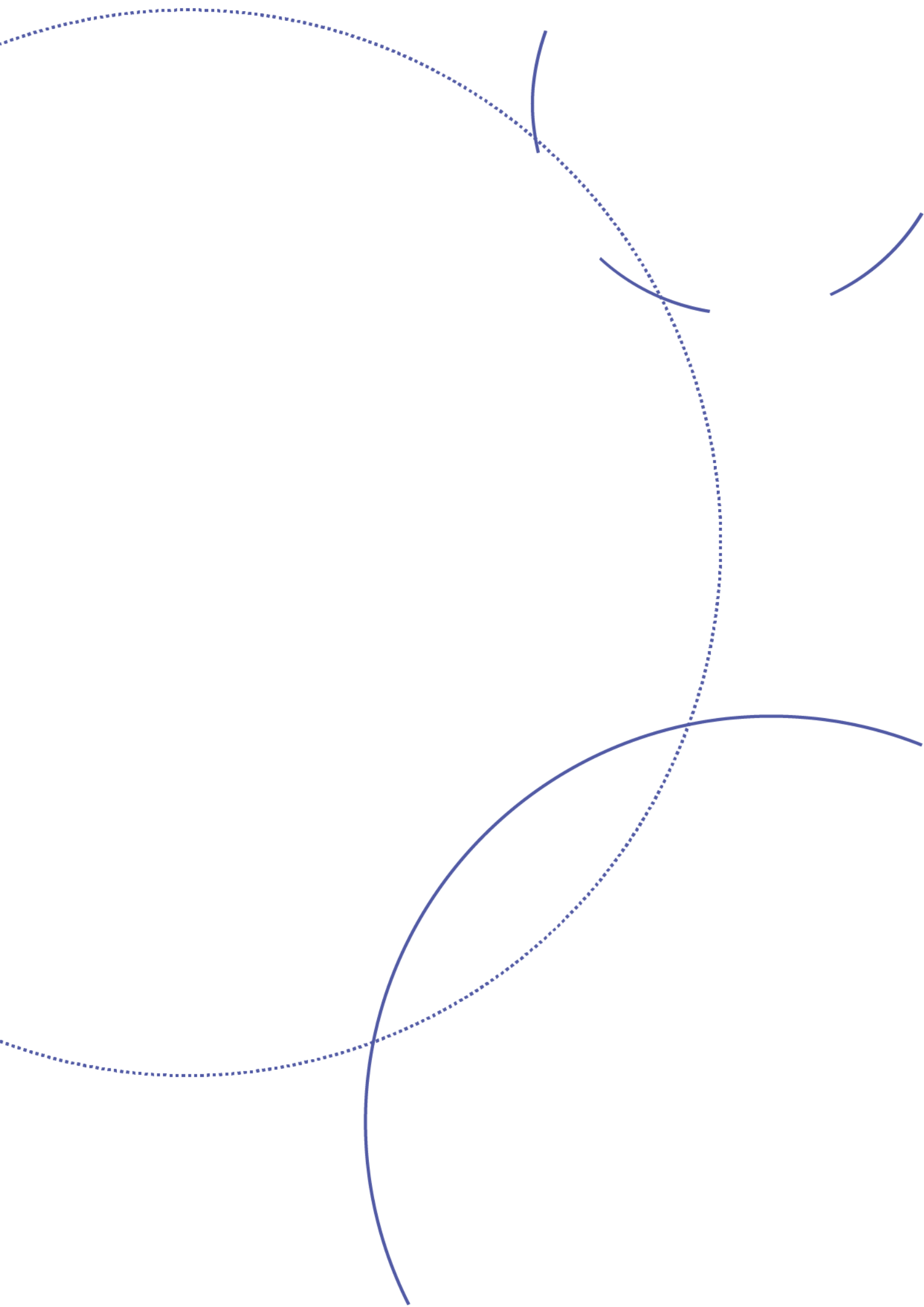
HMICS Custody Inspection Report - Ayrshire

May 2024

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND
Improving Policing Across Scotland



HM Inspectorate of Constabulary in Scotland

HM Inspectorate of Constabulary in Scotland (HMICS) is established under the Police and Fire Reform (Scotland) Act 2012 and has wide ranging powers to look into the *'state, effectiveness and efficiency'* of both the Police Service of Scotland (Police Scotland) and the Scottish Police Authority (SPA).[1] HMICS has a statutory duty to inquire into the arrangements made by the Chief Constable and the SPA to meet their obligations in terms of best value and continuous improvement. If necessary, it can be directed by Scottish Ministers to 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.[2]

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[3] 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.

[1] Legislation, Police and Fire Reform (Scotland) Act 2012, Chapter 11.
[2] For more information about the UK NPM, visit National Preventive Mechanism.
[3] HIS, Framework to inspect healthcare provision within police custody centres, January 2024.

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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.[4] The learning from the review has been used to support the development of a framework to inspect healthcare services within police custody,[5] and for the scrutiny partners to devise a methodology for the joint inspection of police custody centres.

As part of this overarching review, it was agreed that we would undertake two joint custody inspections in order to continue to develop inspection methodology and to complete our inspection framework. We initially inspected and published reports relating to primary custody centres in Lanarkshire and then Tayside. We thereafter commenced a programme of joint custody inspections for 2023-24, which included inspections of custody centres in Dumfries and Galloway and Fife. The third inspection of the programme, to which this report relates, was undertaken in Ayrshire, covering the primary custody centres at Kilmarnock and Saltcoats.

The inspection was carried out jointly by HMICS and HIS, the aim of which was to assess the treatment of, and conditions for, individuals detained at the custody centres. Responsibility for the provision of healthcare services at the custody centres lies with NHS Ayrshire and Arran, and is delivered by Custody and Offender Medical Services (COMS) though a contracted arrangement. This report will provide an analysis of the quality of custody centre operations as well as the provision of healthcare services in the custody centres and consequently makes recommendations for both Police Scotland and the healthcare provider.

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

While recommendations outlined in this report have specific relevance for Kilmarnock and Saltcoats 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 2 from this report to have such relevance.

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

The onsite stage of the inspection took place in February 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 November 2023. We assessed the physical environment, including the quality of cells, and observed key processes and procedures relevant to police custody operations. We also spoke with people detained at the custody centres during our inspection and interviewed custody staff and healthcare professionals during our visit.

This report, similar to our joint inspection of custody in Fife, highlights our concerns regarding a lack of consistency in the recording of information on the National Custody System. Whilst some aspects of custody centre operations were recorded well, such as hand-over records, the recording of medication provision was found to be inconsistent. We also found areas of concern relating to controlled drugs recording and storage.

Our review of NCS records highlighted issues regarding incongruence between some of the risk assessments undertaken and the corresponding care plans put in place. In particular, there was significant use of CCTV monitoring to mitigate risk but without satisfactory recording and a related rationale.

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.[6] Police Scotland has made progress in implementing previous recommendations and improvement actions in respect of custody services and is actively working to address those that remain outstanding.

We wish to thank the officers and staff of the Criminal Justice Services Division of Police Scotland, NHS Ayrshire and Arran and Custody and Offender Medical Services.

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

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

[6] Our custody inspection reports are available on our website at HMICS.

Key findings

- The physical condition of both centres, despite their being within an older part of the custody estate was generally good. Both centres were clean and reasonably well maintained.

- Kilmarnock custody centre was accessed via an open rear yard which doubles as a parking for operational vehicles. This area had no gate but had a *'Police vehicles only'* notice painted on the roadway.

- The holding space at Kilmarnock is a walk-through room secured by an electronic keypad-controlled door fitted with a sprung closing device. However when left to swing close, the lock did not fully engage, and therefore was not completely secure.

- In Saltcoats, the rear access door was covered by a flat roof which housed a fixed but unsecured maintenance ladder. This could afford access to the station roof in the event an unsecured detainee gained access to the flat roof.

- All cells in both centres inspected during this visit were found to be clean, well-appointed and in generally good physical condition with only minor defects. We found washing facilities to be good. The custody centres were well maintained and suitably equipped with appropriate materials, which we considered to be of a very good standard.

- Custody staff occasionally undertake cleaning duties, however stated they have not received any formal training in this regard.

- All cells within both centres were equipped with ceiling mounted CCTV facilities linked to the main office. At Kilmarnock, ten cells located in the adjoined Sheriff Court building were routinely utilised at weekends to expand capacity to 24 cells. These have no CCTV.

- The physical layout of both facilities, particularly in Saltcoats enable segregation, however this is not routinely employed other than with children/young people.

- General storage at Kilmarnock is very limited. In Saltcoats, the clothing store doubled as storage for reading materials and housed the intoximeter machine.

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

- Both facilities had clear, suitably located, multilingual posters within the charge bars for identifying language translation requirements. However, there were very few posters conveying information to detainees as to their broader rights, wellbeing and access to support services.

- We found prisoner property arrangements to be in very good order.

- The use of electronic tablets to record cells checks was not consistent across the custody centres.

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

- The offer of a referral to a third sector agency for support was made on every occasion where it was appropriate.

- In our review of NCS records we found evidence of disparity between some risk assessments and the corresponding care plans. In particular, there was significant use of CCTV monitoring to mitigate risk but without satisfactory recording and a supporting rationale.

- The recording of medication and rationales for decisions was inconsistent and four records indicated detainees had been subject of extended custody periods without a suitable rationale being recorded.

- It was notable that whilst 54% of the sample we examined were recorded as high risk, a considerable majority of these, were placed on standard level 1, 60-minute observations. While risk was mitigated by use of enhanced CCTV observations, the recording of risk and care plans was confusing, inconsistent and utilised a locally adopted observation nomenclature that did not correspond to established naming conventions.

- Our examination of NCS highlighted that in four records, after a decision to release a detainee had been recorded, the detainee was held for a further period of between 8 and 12 hours before they left custody. In three instances the delay possibly related to the detainee being intoxicated but there was little recorded information to explain why a delay in release was necessary or lawful.

- From our review of records, it was evident that there was a limited amount of quality assurance and audit of key processes taking place at the custody centres. We are aware that there was a previous national structure in place that required an increased level of audit. We have referred to a previous recommendation made in respect of this issue within this report. We will pay particular attention to the effectiveness of quality assurance and audit during future custody inspections.

- The consistency and compliance with undertaking a handover between staff teams at both centres was good, with handovers recorded in 36 (78%) of the 46 records. In the remainder, a handover was not necessary.

- During on-site interviews with independent custody visitors, they stated that from their previous visits, the quality of care and welfare and processes had become more consistent and improved.

- The NHS board delivers healthcare to the custody centres through a contracted arrangement with Custody and Offender Medical Services (COMS). The COMS service is peripatetic and provides a 24/7 on-call service, with a Forensic Medical Examiner (FME) and Mental Health Nurse available. Healthcare was well managed, with NHS Ayrshire and Arran and COMS providing a clear management structure, monitoring and oversight.

- Overall, the recording of the provision of medicines on the National Custody System was poor. There appeared to be a reliance upon the *'dosette box'*[7] used to dispense medicines for accurate information, however these are shredded after use resulting in the partial loss of accurate dispensing records.

- We found that the NCS recorded the actual medication as *"other"* with no specification of medication and dispensing frequency was often noted as *"as required"* with no specific timing indicated.

- There was no clinical supervision in place for nursing staff, though senior FMEs were routinely available for advice and to discuss complex cases.

- Inspectors found that *'sharps bins'* were not consistently labelled or had temporary closures in place.

- Whilst there was evidence of oversight of infection prevention control (IPC) in both custody centres, there was no identified IPC lead.

- In both centres, clinical examinations were generally carried out in a dedicated treatment room, although healthcare staff informed us that the door was generally kept open with a member of staff positioned outside the room.

- We found areas of concern relating to controlled drugs recording and storage.

- Despite the availability of nicotine replacement therapy (NRT) and accompanying standard operating procedure, feedback from detainees suggested they were not aware NRT was available.

- There was evidence of signposting detainees to community support services e.g. mental health, substance use, health & wellbeing, harm reduction, peer support and family support.

[7] Dosette Boxes are containers that have separate compartments for days of the week and times of the day which are used to assist people with taking their medication. These are also referred to as blister packs or compliance aids.

Recommendations

Recommendation 1

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

Recommendation 2

Police Scotland should ensure that custody staff have a clear understanding of what response is required for each of the defined observation levels and that these are applied consistently.

Recommendation 3

NHS Ayrshire & Arran should ensure formal and regular clinical supervision is available to all nursing staff.

Recommendation 4

NHS Ayrshire and Arran should ensure that sharps bins are managed in line with current guidance.

Recommendation 5

NHS Ayrshire and Arran should ensure that infection prevention and control training is made available to all healthcare staff.

Recommendation 6

NHS Ayrshire and Arran should introduce an audit to assure themselves of the quality of medicine prescribing in the police custody centres.

Recommendation 7

NHS Ayrshire and Arran must ensure effective processes are in place for the recording of controlled medicines to ensure patient safety and compliance with regulatory requirements.

Recommendation 8

NHS Ayrshire and Arran should work with the custody centres to increase detainee awareness of the availability of nicotine replacement therapy.

Areas for improvement

Areas for improvement	Number
The custody centres should ensure routine checks include security risks and apply appropriate measures to mitigate any weaknesses identified.	1
The custody centres should ensure a suitable mix of staff and detainee information posters are distributed throughout relevant areas within the centres.	2
The Saltcoats custody centre should ensure existing storage capacity is utilised effectively to ensure appropriate accommodation is afforded to the housing of essential operational equipment.	3
The custody centres should routinely consider the use of separate cell corridors or separated cells for gender-based segregation to improve privacy, where considered appropriate.	4
The custody centres should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.	5

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,[8] which is updated and amended regularly to reflect changes in practice guidelines and expectations.

2. While custody throughput volumes have been in steady decline since the implementation of the Criminal Justice (Scotland) Act 2016 (the 2016 Act),[9] the last financial year saw a slight increase. Table 1 below, outlines Police Scotland's annual custody throughput figures from 2018-19 to 2022-23. There are a variety of contributory factors for the previous reduction in throughput over recent years. This can, in part, be attributed to Police Scotland's proactive approach to divert people away from custody centres when it is considered safe and appropriate to do so. However, the moderate 3.5% increase in national custody throughput for the period 2022-2023, could be attributed to a post-pandemic return to more routine and expected operational practice in policing. Current throughput figures remain considerably lower than pre pandemic levels.

3. Custody centres in Scotland are organised into clusters, each led by a Cluster Inspector. The custody centres we visited during this inspection, Kilmarnock and Saltcoats police custody centres, serve the Sheriffdom areas of Kilmarnock and Ayr. Detainees from this area can be taken to both Kilmarnock and Saltcoats. Both centres are located within the local area police stations.

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

4. The overall cell capacity at Kilmarnock is 14 cells, however at night and at weekends they also use 10 cells within the adjoined Sheriff Court. Saltcoats has 20 operational cells. The cell provision is considered suitable to meet demand. The annual throughput from April 2022 to March 2023 at Kilmarnock was 3313 and at Saltcoats it was 3131. When considering the total throughput across both centres, these figures show a small reduction from the previous year (see table 2).

5. The cluster also includes ancillary custody centres at Lamlash and Millport. Ancillary centres are not routinely staffed but can be opened by trained staff as and when required. The ancillary centres were not physically inspected however two custody records from Lamlash were examined remotely.

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

Table 1 - National custody throughput

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

Table 2 - Custody centre cell capacity and throughput

Custody centre	Number of cells	2021-22	2022-23
Kilmarnock	14 (plus 10 court cells)	3684	3313
Saltcoats	21	2964	3131
Lamlash (ancillary)	2	30	29
Arran (ancillary)	1	2	0
Total	48	6680	6473

7. The NHS board delivers healthcare through a contracted arrangement with Custody and Offender Medical Services (COMS). The COMS service is peripatetic and therefore not based within a single custody centre. It provides a 24/7 on-call service, with a Forensic Medical Examiner (FME) available.

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

8. Each staff team at Kilmarnock was made up of a police sergeant (PS), a CJPCSO team leader, and three or four CJPCSO staff, as it varies by team. Each team at Saltcoats was made up of a police sergeant, a police constable (PC) and three CJPCSO's. At the time of the inspection, two of the CJPCSO posts were vacant and recruitment was underway.

Independent custody visitors

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

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

11. During our inspection of Kilmarnock, we met and spoke with independent custody visitors who explained they rarely experience delays in gaining access and where there is, it is always accompanied with a good explanation by staff. They considered staff to be very welcoming and accommodating. They stated that staff appreciation and understanding of their role had improved. Custody visitors were of the opinion the quality of custody provision has improved with care and processing having become more uniformed and consistent since the formation of a dedicated national custody division. They were complimentary of the staff at both centres.

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

Methodology

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

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

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

15. Inspectors from HMICS and HIS visited the custody centres at Kilmarnock and Saltcoats on 5th and 6th February 2024. During the inspection, we examined the treatment of, and conditions for, detainees. We observed key custody processes and assessed the custody environment, condition of cells and facilities for detainees. We undertook interviews with custody staff and managers, as well as healthcare practitioners (HCP) that were present during our visit. We also spoke with people detained in custody at the time.

16. A proportional sample of custody records were examined from those created on the national custody system (NCS) in Ayrshire during the month of November 2023. Of the 636 records created during that period, 333 related to persons processed at Kilmarnock, 301 at Saltcoats and 2 at Lamlash. We examined 46 records, 23 from Kilmarnock, 21 from Saltcoats and 2 from Lamlash, which represents a 7% sample.

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

17. 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.

18. 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

19. The custody centres at Kilmarnock and Saltcoats were incorporated into the footprint of existing operational police stations. Both had single story layouts containing two separate charge bars with Saltcoats constructed with two cell corridors comprising 20 operational cells. Kilmarnock was comprised of a single cell corridor with a capacity of 14 cells. This centre was connected to the neighbouring Sherrif Court building via a secure corridor, which enabled the routine utilisation of the available 10 court cells, increasing overall capacity to 24 during weekends when the courts are closed.

20. We examined the route into both custody centres, the confines of which were suitably protected by CCTV systems linked to respective staff offices. Kilmarnock was accessed via a lane leading from the public road and while fading road markings state *'reserved for police use only'*, access was not secured by any form of closure or gate. The limited parking area at the entrance to the custody centre was also utilised by a variety of operational police vehicles, further restricting accommodation to one custody vehicle. The yard was clean and free of unnecessary items.

21. Saltcoats custody centre was accessed via a secure vehicle dock capable of accommodating a single van-sized vehicle and is secured by a fully operational keypad and CCTV controlled, sliding iron gate which was surrounded by a further high secure perimeter fence and cctv intercom controlled sliding gate surrounding the main station car park. The yard was clean and free of unnecessary items with the exception of an unsecured shovel leaning against the wall adjacent to the custody access door.

22. In Saltcoats, the rear access door was covered by a flat roof approximately ten foot in height which housed a fixed but unsecured maintenance ladder, which could afford access to the station roof in the unlikely, though not impossible event an unsecured detainee gained access to the flat roof via the adjacent drainpipe or from a vehicle roof.

23. At Kilmarnock, the holding area, was secured externally by an electronic locking door controlled by CCTV intercom and an internal keypad-controlled door. It was noted however, when the exterior door was allowed to swing close, the door did not fully engage and the locking mechanism failed to secure rendering the holding area and insecure yard beyond it, a potential security hazard. This issue was raised with the custody sergeant and recorded. A note was made for remedial action to be undertaken.

Area for improvement 1

The custody centres should ensure routine checks include security risks and apply appropriate measures to mitigate any weaknesses identified.

24. Both holding spaces were well lit and in good order but were only capable of accommodating one detainee resulting in frequent queues during busier periods and use of the open plan space at Saltcoats was anecdotally dependent on the detainee being of agreeable and compliant disposition.

25. Charge bars in both centres contained two seated workstations stations separated by solid partitions, which owing to their shallow depth offered little in the way of discrete separation of the processing spaces. The workstations were not elevated from the custody side floor and one workstation was separated from the custody side by a secure retro-fitted Perspex safety screen.

26. Detainee property storage at both centres was located in CCTV monitored rooms immediately adjacent to the charge bars and was provided by way of lockable floor mounted steel lockers. Both the processing areas are covered by multiple CCTV cameras, including overhead and microphones. We found prisoner property arrangements to be in very good order.

27. In both centres, the charge bar areas were spacious and practically situated adjacent to entrances and main staff offices. Each processing area afforded access to additional facilities such as the well-appointed medical examination rooms, single staff only toilets, storerooms, photograph/impressions intoximeter rooms, DNA storage, interview rooms as well as two detainee access rooms, in each custody centre, which, owing to their limited intended use were being utilised as temporary stores for ancillary materials. Access to the wider station was afforded via keypad-controlled access doors.

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

29. There was sufficient, clearly visible and practically located safety materials, first aid, defibrillator, fire safety equipment and metal detectors.

30. Both facilities had clear, suitably located, multilingual posters within the charge bars for identifying language translation requirements. There were however, very few posters conveying information to detainees as to their broader rights, wellbeing and access to support services.

Area for improvement 2

The custody centres should ensure a suitable mix of staff and detainee information posters are distributed throughout relevant areas within the centres.

31. In each centre, staff offices were spacious, tidy, well-lit and well-appointed, offering multiple workstations for custody staff and co-located public counter staff, who's workstations were situated as to face away from the multiple CCTV screens displaying footage from cells and the wider complex. Whiteboards were clearly visible and used for relevant detainee care and welfare notes in each case. Suitable rest and refreshment spaces were provided both within the main office and wider station footprints.

32. Detainee Interview rooms in Kilmarnock though well-lit, were cramped owing to the size and amount of unsecured furniture and were poorly ventilated owing to the glass brick windows and poor air-conditioning, requiring manual fans to improve airflow. The room was not covered by the custody CCTV system but was equipped with an affray strip, which is an emergency assistance call system.

33. Saltcoats contained one interview room which was well-lit, ventilated and relatively spacious with unfixed furniture. The room was covered by the custody CCTV system and was equipped with affray strip.

34. In Kilmarnock, there are two separate in-cell CCTV observation rooms containing a single TV monitor located in the cell corridor. One of the rooms had lighting and a glass brick window. The second room had no natural light, and the electrical light was dysfunctional and flashing constantly. This was previously logged as a fault. Both rooms were poorly ventilated and equipped only with a fan and were also used for alternative storage of ancillaries. The faulty light was raised with staff at the time of our inspection.

35. The CCTV observation room in Saltcoats was located in a room adjacent to the charge bar and was equipped with CCTV and affray strips. It contained two TV monitors separated by a screen, had comfortable seating, artificial lighting and was reasonably well ventilated. However, it also contained the DNA fridge and other electronics so was warm as a consequence.

36. CCTV viewing facilities in both centres contained clearly posted observation guidance relating to awareness of detainee risk factors.

37. Heating and ventilation in both centres were described by staff as being appropriate and adequate in general albeit less so for the interview rooms located at Kilmarnock.

38. Storage space at both centres was limited necessitating the re-purposing of other rooms to accommodate storage of custody related materials. In Saltcoats, the clothing store also stored reading materials and housed the *'Intoximeter'* breathalysing machine, which if better management of existing stores was employed, could be relocated to a more functional and appropriate dedicated space.

Area for improvement 3

The Saltcoats custody centre should ensure existing storage capacity is utilised effectively to ensure appropriate accommodation is afforded to the housing of essential operational equipment.

39. Overall, both custody centres were adequately provisioned with well situated and fully functional CCTV cameras linked to the charge bar and staff offices. Staff are not issued with personal alarms, however the majority of wall surfaces within the custody centres, including adjacent rooms and access corridors, were fitted with multiple affray strips. These easily accessible, highly visible illuminated panels are linked to a central control pad located in the office area. In Saltcoats, three locations containing the affray system were tested during the inspection as part of the scheduled weekly tests undertaken at both facilities.

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

41. There was sufficient, clearly visible and practically located fire safety signage, emergency lighting and materials, including a supply of rigid handcuffs for the evacuation of detainees, located throughout each custody centre. Recent physical evacuation drills had taken place at both centres in September 2023, both with notional movement of detainees at Kilmarnock and actual movement of staff role playing as detainees at Saltcoats, which we consider to be good practice.

42. The general condition of the custody centres was good. There was evidence of minor damage to some parts of the buildings as well as general maintenance requirements, however these instances were documented and subject of appropriate remedial action by staff.

Condition of cells

43. The cells complex at Kilmarnock comprises 14 cells with one cell temporarily closed which had been logged and scheduled for repair. The cells were separated as 12 and 2 with the two locally termed *'female'* cells being located at the far end of the same corridor but separated by other rooms and adjacent to the sole shower facility.

44. At the time of inspection, nine cells were unoccupied and available for viewing. The ten cells located in the connected Sherrif Court building were not available for direct viewing, albeit all cells were fully operational with no defects logged on the records.

45. The cells complex at Saltcoats comprise twenty operational cells with one cell permanently re-purposed as a store for ancillaries. The cells were distributed with ten in the original block, one original direct observation cell which is also a 'dry cell' and nine in the *'new'* block. All were available for inspection.

46. The physical layout of Saltcoats and to a lesser degree Kilmarnock, provides for gender or age-based segregation opportunities, however the practice was not routinely employed and only tended to be used for the separation of children or young people being directly supervised.

Area for improvement 4

The custody centres should routinely consider the use of separate cell corridors or separated cells for gender-based segregation to improve privacy where considered appropriate.

47. 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 charge bar and custody office and viewing centres, where it could be viewed in various configurations on high quality monitoring screens. The ten court cells in Kilmarnock did not have in-cell CCTV, although cell corridor images are available to be viewed in the custody office.

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

49. The cells in both centres were equipped with internal intercom/call buttons linked to the charge bar and staff office. The cell with the raised plinth in Saltcoats had two intercoms one at bed level and one at the door. All those available for inspection were tested and were fully operational.

50. The nine cells in the *'new block'* at Saltcoats contained toilets with internal controlled flush as well as *'anti-ligature'* automated internal hand washing and drying facilities integrated into the cell walls. The remaining eleven cells at Saltcoats, and all cells at Kilmarnock, contained toilets with external controlled flush with no in-cell hand washing facilities.

51. Additional washing facilities were available in the form of two separate shower areas with six washbasins in Saltcoats and a single shower and two separate washbasins in Kilmarnock. All facilities were clean, well maintained and suitably equipped with appropriate materials which we considered to be of a very good standard.

52. There were no accessible cells or induction hearing loops within either facility and therefore none of the cells were fully compliant with current equality legislation,[13] in respect of accessibility for people with mobility challenges. There was one cell located within the new block at Saltcoats with a raised plinth and double call button intercom. Both centres have at least one shower facility capable of accommodating wheelchair access. Staff stated that when a detainee has accessibility requirements, consideration is given to conveying them to the most suitable and appropriate custody centre, based on availability, distance and identified needs.

[13] Legislation, Equality Act 2010.

53. All 24 cell doors at Kilmarnock and nine located in the *'new block'* at Saltcoats were of contemporary construction with three position service hatches, vertical peep grille and fitted with slam locks. The remaining eleven doors in Saltcoats were of older construction with two position service hatches, peep hole and fitted with slam locks.

54. All cells in both centres were equipped with smoke detectors linked to an indicator VESDA VLS panel.[14] Fire alarm, Automated External Defibrillator and affray alarm tests were subject of weekly testing regimes and were performed during inspection.

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

56. 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 Kilmarnock and Saltcoats custody centres, we do not intend to make an additional recommendation in this regard.

[14] 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.

Custody centre staffing

57. Kilmarnock has a CJPCSO team leader on each team, Saltcoats does not. When a team leader is not present, their responsibilities fall to the sergeant. This is the same model as we found in Fife custody. Kilmarnock and Saltcoats have similar capacity and similar throughput to each other.

58. The team leader is the line manager for CJPCSOs at both centres but is seldom able to visit staff at Saltcoats and has no input on day to day operational decisions, which fall to the sergeant. At Saltcoats, the sergeant is responsible for all aspects of custody business. At Kilmarnock, supervisory responsibility is shared unless the CJPCSO team leader is absent, then the sergeant will manage it alone. A CJPCSO team leader is never left to manage a centre without a sergeant. It was apparent that the absence of a team leader had limited impact on operations because in such circumstances, the sergeant at Kilmarnock assumed full responsibility, as they routinely do at Saltcoats.

59. 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 care and welfare, but only after a sergeant has made the initial decision, which introduces split responsibilities. The role of the team leader was raised in our inspections of Tayside and Fife, but not in Dumfries and Galloway where the role does not exist. We commented on the importance of ensuring clarity regarding the role of custody supervisors in our joint custody inspection report on Tayside which stated that:

"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."[15]

60. The cluster inspector and team leader were positive about the team leader role, though noted the staffing and geographical challenges. Most others we interviewed questioned what benefit it brought in Ayrshire compared to larger centres, such as Glasgow, where they considered the role to be more valuable.

[15] HMICS, Custody Inspection Report - Tayside, Recommendation 2, 20 July 2023.

61. 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.

62. The premise of the PC-led model is that suitably trained, experienced and approved Police Constables, who have the proven capability to perform the duties of Custody Officer, assume the lead role for coordinating onsite custody operations under the remote supervision of a custody sergeant and such centres are limited to ten detainees. Responsibility for authorising arrest, liberation decisions and care and welfare decisions rest with the remote sergeant.

63. Saltcoats is never operated on a PC-led basis, while Kilmarnock occasionally is. Kilmarnock is favoured for this as it has smaller capacity. On these occasions, the constable will be moved from Saltcoats to Kilmarnock and they assume the lead, even if there is a CJPCSO team leader present. While sergeants accepted that criminal justice decisions could be made remotely, some had some concern that they are remotely responsible for the health, care and welfare of detainees at Kilmarnock when it is PC-led. As such, they rely on the staff at Kilmarnock to recommend decisions.

Arrival at custody and booking-in process

64. During the inspection, we observed six detainees being booked into custody. In all instances, staff were thorough and professional. They built a good rapport with detainees and were respectful. In each case, staff at the custody centre received advanced notification of detainee particulars from arresting officers either by telephone or radio to enable the commencement of background checks. Custody staff checked PNC, CHS, the national custody system and iVPD.[16] The information gathered helped to inform the initial risk assessment and enabled swifter processing. We consider advance checking of antecedent information to be good practice.

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

65. When detainees arrived at the custody centres, one officer remained with them in the police vehicle while the other officer entered the custody centre to discuss the circumstances with the sergeant. This was to afford sufficient information to allow the sergeant to authorise the arrest. This process is typical across most custody centres.

66. Part of the sergeant's role is to record the necessity and proportionality of arrest under the Criminal Justice (Scotland) Act 2016 and apply a rationale for that and any subsequent Criminal Justice decision making. The final decision for the sergeant, is to consider the disposal for each detainee and accompany that with a detailed rationale on the NCS. In our examination of the NCS, we found that the recording of a sergeant's authorisation of arrest was generally good.

67. In our examination of the NCS, we noted in four records, that after a decision to release a detainee had been recorded, the detainee was held for a further period of between 8 and 12 hours before they left custody. In three instances the delay possibly related to the detainee being intoxicated but there was little information recorded to explain why a delay in release was necessary.

Recommendation 1

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

68. We assessed the average waiting time relevant to the booking-in process during our review of NCS records. The average time of waiting within the sample was 14 minutes. This figure compares favourably with the national average which is 26 minutes. This figure is almost identical to our findings in Fife and is five minutes longer than that found in our inspection at Dumfries and Stranraer.

69. The detainees we witnessed being processed were managed in a professional, proportionate and respectful manner by arresting officers under the guidance of custody staff. Staff politely explained the process to put detainees at ease.

70. 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 may be 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 available from the charge bar.

71. Of the 46 records we examined on the NCS, 12 detainees were strip searched and each was appropriately authorised. The recording of searches was generally good with only one record missing detail. None of the detainees reviewed were the subject of an intimate search. We saw evidence of transgender detainees being searched in an appropriate manner and in accordance with policy.

72. Custody staff were responsible for taking criminal justice fingerprints and DNA samples from detainees. In cases where evidential fingerprints or DNA are required, it is the responsibility of the investigating officer to obtain, store and submit them for analysis. Custody staff were also responsible for completing Nexus[17] checks in relevant cases. Related processes observed during our inspection were undertaken efficiently and effectively.

Legal rights

73. 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 the NCS custody system ensure compliance with this legal obligation and our examination of NCS records confirmed that all detainees in the sample were offered a letter of rights. It was accepted in 44 (96%) cases and declined on 2 (4%) occasions.

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

74. From our examination of custody records, we found that a Police Interview - Rights of Suspects (PIRoS) form had been completed appropriately for all detainees where relevant. PIRoS was completed in 14 of cases. In 27 cases the detainee asked for a solicitor to be informed. This included some where the detainee initially declined but then changed their mind. Notification to a reasonably named person was requested in 20 cases from our sample. In each case there are notes to explain that contact was made or attempted.

75. In the sample, there were no records that indicated the use of an interpreter, and none appeared to indicate that an interpreter was necessary. In addition to the four child records that required an adult, there were two records that indicated that an appropriate adult was required.

76. From our examination of NCS, 20% were released before 6 hours, 26% were held for between 6 and 12 hours. 28% were held for between 12 and 24 hours, 12% were held for between 24 and 48 hours, and 15% for longer than 48 hours. These cases related to detainees held over a weekend for court. The average time in detention for the 636 records in November 2023 was 16 hours and 39 minutes. The longest period held in police custody was 77 hours. Having been arrested early on a Friday morning, the detainee missed the 04:00 hours deadline for court and had to wait until the following Monday. This deadline is set by Crown Office and Procurator Fiscal Service (COPFS). This course of action is typical across Scotland over a weekend as courts do not sit on a Saturday or Sunday.

77. Aging police custody centres arguably do not 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 Ayrshire custody centres, there is no continuous on-site medical service and exercise is not available. 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.

78. As well as improved outcomes for detainees, there would be benefits to Police Scotland and partners by reducing the disproportionate weekend spike in demand of detainee care, cell capacity and transfers.

79. From our sample, 27 (59%) detainees were held for court, however the annual court disposal rate for the year to October 2023 in Ayrshire is 39%, which is also the national average for the calendar year 2022. HMICS appreciates that CJSD has made significant effort to reduce these numbers further in accordance with the legislative requirement for the presumption of liberty.[18]

80. Of the remaining detainees, 12 were released on an undertaking, two were referred to the children's reporter, two released for summoning report, two with a fixed penalty notice and one was released without charge.

Risk assessment and care plans

81. Of the 636 records from which we drew our sample of 46, there were seven records for a younger child (aged 15 and under) and seven records for older children (16-17), and we sampled four each of these. This data reflects that very few children were brought to custody during the period examined.

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

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

83. This initial risk assessment process allows custody staff to determine a bespoke care plan for detainees and involves determining whether the person presents high or low risk and applying a corresponding level to determine the appropriate frequency of wellbeing observations. This approach is based on an assessment of threat, risk and vulnerability. Responses to the vulnerability questionnaire and the subsequent care plan are recorded on NCS. Based on the outcome of the risk assessment, detainees are subject to observations and rousing[19] in accordance with the following standardised scale:

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

[19] 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.

84. Of the sample we examined, 43% of detainees were intoxicated on arrival, 15% declared they were alcoholics and 20% were drug dependent. Fifty four percent disclosed a mental health condition and 39% reported they had previously self-harmed or had attempted suicide. Forty three percent were on prescribed medication and 20% stated they had difficulty with reading and writing. Forty six percent had consumed alcohol and 33% had used drugs prior to arrest. Almost all had some form of criminal or police information record. These statistics are similar to those we found in our recent inspection of Fife custody centres 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 centres on a daily basis.

85. The vulnerability of 21 (44%) detainees was assessed as low and 25 (54%) were considered to be high risk. In each instance, there was a comment on the NCS to explain why a high risk decision was made. There were a variety of reasons which included current and historical mental health conditions, medical conditions, intoxication levels, need for prescribed medicines and presentation. In one case, the detainee answered 'No' to most questions but further enquiry by officers discovered previous suicidal ideation and self-harm information that merited a high risk rating. We consider this to be good practice.

86. It was notable that whilst 54% of detainees were assessed as high risk, a considerable majority of these, were placed on standard Level 1, 60 minute observations. This was mitigated somewhat by a significant use of enhanced CCTV observations.

87. In 19 instances, the notes indicated that a detainee was to be placed on level 2.5 observations. 2.5 is understood to be local nomenclature to describe level 2 enhanced observations. In each of these instances, the NCS observation page recorded them as being on level 1, 60 minute observations and the cell check entries were also hourly. This is despite policy indicating that level 2 enhanced CCTV regimes should accompany 15 or 30 minute visits.

88. In the cases of three child records, the NCS show them as being in a cell on level 1 observations, however analysis of other entries suggested that they were permanently accompanied which would be level 4. In another case, a detainee was on significant medication and had attempted suicide by hanging six months before arrest. They were deemed to be high risk but placed on level 1 observations by the staff member booking in with no other mitigation options considered. The initial risk assessment was not endorsed by a team leader or sergeant. Whilst a staff member may recommend a care plan, policy indicates that the responsibility for setting the care plan lies initially with the sergeant and thereafter a team leader if one is on duty.

89. In an additional case, a detainee was intoxicated on arrival and failed to answer some vulnerability assessment questions. They stated they had been punched to the head and suffered PTSD and OCD. They were initially deemed to be high risk but despite the information provided, were placed on level 1 observations. There was no comment to indicate that enhanced CCTV observations had been considered and there was no note of a referral to a HCP. We would consider that such decisions made by staff should be supported by medical advice.

90. It was evident from our analysis of NCS, and onsite inspection, that there was a practice of adopting level 1 with enhanced CCTV viewing as tactical option. NCS does not provide an option to indicate periodic enhanced CCTV viewing and therefore this can only be gleaned from free text on the system. Whilst the use of 2.5 as a term has been discouraged, its application in these instances could be better described as level 1.5. As a result, the recording of risk and care plans is confusing and inconsistent.

Recommendation 2

Police Scotland should ensure that custody staff have a clear understanding of what response is required for each of the defined observation levels and that these are applied consistently.

91. The use of level 2 enhanced CCTV viewing as a tactical option is described by staff as having significantly reduced the need for local policing officers to be deployed to constant observation duties, which is broadly welcomed. It should be noted however, that occasional checks whilst passing a CCTV monitor is a marked step downwards from constant CCTV observations. There is a risk that this option is adopted because it reduces resource pressure when perhaps, at times, the risks merit a more intrusive regime. In addition, the more cursory checks of CCTV monitors are not routinely recorded.

92. Conversely, during our onsite inspection we were told that previously, detainees who merited something more than standard observations were placed on constant CCTV observations, because there was no other option. The introduction of enhanced CCTV observations provides a welcome tactical option that is believed to meet the duty of care but can be less impactful.

93. We commented on the need for better consistency and quality regarding assessing risk, applying appropriate care plans and ensuring there is high quality recording on the NCS in our joint custody report on Fife. Those recommendations are relevant in our inspection of Ayrshire custody centres. **Recommendation 5** from that report states:

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

And **Recommendation 6** states:

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

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

94. The Custody Care and Welfare standard operating procedure allows for night-time rousing to be reduced to every three hours in certain low risk circumstances. It was noted that on those occasions where a detainee was held for several days, staff did not adopt the option to make visits every three hours. Cell check entries were examined on the NCS for all the records that were sampled. All cell checks were recorded at the correct times.

95. Information on criminal justice decisions, and in relation to care and welfare plans, should routinely be passed from one shift to another. This should be in the form of a handover briefing between sergeants or team leaders. It should be recorded on the NCS and is key to managing and re-evaluating risk. There were notes recorded in 36 of the 46 records to show that a handover between shifts had been conducted and it was not applicable in the remainder. The consistency and compliance of adding a handover in Ayrshire custody centres was notable. We consider this to be good practice.

Detainee care

96. We interviewed six detainees. On checking their cells, all detainees had appropriate mattresses, numerous blankets and pillows. There were books in the cells and containers from meals that had been provided. They stated that custody staff had been efficient, respectful and made regular enquiries about their wellbeing.

97. In our examination of NCS records, we found that the recording of cell visits were punctual and accurate. During our inspection, we noted that staff practice was to conduct observations and note the time and response on a piece of paper before returning to the office to update the details onto the NCS. Both custody centres have been provided with hand-held electronic tablets to carry out this task, however these were not being used. Sergeants at Saltcoats said that tablets are used except when there are only a few detainees. In these circumstances they believed returning to the office to update the NCS to be quicker.

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

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

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

99. Just one record indicated that restraint techniques were required and that related to the use of handcuffs. There was no record of spit masks or leg restraints having been used in any of the records. Clothing was removed in just two of the 46 cases we reviewed. Both related to the provision of anti-ligature clothing and there was sufficient detail in the record to justify the decision.

100. Twenty eight of the 46 records we sampled indicated that meals had been provided and eight detainees had declined the offer of food. Those records were correctly updated within the meal manager section of the NCS. 54% of records referred to the offer of a drink. In six cases the detainee was held for only a few hours where the offer of a drink may not have been necessary. In the remaining 15 records, we felt that a drink should have been offered, this included one detainee held for 77 hours. It is unlikely that they were not offered a drink but rather it was not recorded.

101. Detainees are typically offered a wash first thing in the morning prior to attending court. Of the 46 records, 27 (59%) detainees were held for court and 3 (6%) of those records had no entry to indicate that a wash was offered. No detainee was offered exercise and there are no facilities for exercise. Just one record included the offer of reading material although in our interview of detainees we found all had been offered a book.

102. The offer of a referral to a third sector agency for support was made on every occasion where it was appropriate.

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

104. The areas of concern, as detailed above, predominantly relate to risk assessment and care plans, observation regimes and rationales for decisions. This is a similar issue to one we found in our recent inspection of Fife, albeit slightly different in the detail. It does highlight our finding that the assessment and decisions relating to care and welfare are inconsistent and sometimes absent. Another concern identified, was the recording of medical information and medicine dispensing, which was often inaccurate and inconsistent.

105. Current practice in Ayrshire is that only eight custody records are dip sampled for audit and quality assurance purposes per month. Given that there were 636 records in November 2023, eight 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 whilst meeting the care and welfare needs of the detainee.

106. The issue of quality assurance and audit was addressed in our inspection of custody centres in Greater Glasgow division in June 2019. **Recommendation 5** from that report remains relevant and 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."

We will pay particular attention to the effectiveness of quality assurance and audit processes as we undertake joint custody inspections during the course of the 2024 – 25 programme.

Staff training

107. All supervisors have completed two mandatory custody related courses lasting a total of five days. This includes the Custody Officers Induction course lasting three days and two days National Custody System training. They are trained in first aid, officer safety, fire safety, food hygiene and data protection. Some staff, including a sergeant we interviewed, were not trained in CHS and PNC which added pressure to other staff to carry out critical antecedent checks.

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

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

This applies nationally and has specific relevance for Kilmarnock and Saltcoats custody.

109. Inspectors were informed that all custody officers and staff had received training to administer Naloxone.[20] 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. Whilst all are trained, presently only sergeants and constables can administer Naloxone. We saw that Naloxone was available for use in the custody centres and, under the current operating model, a sergeant or constable was available at the centres.

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

Healthcare

110. A healthcare professional (HCP) was required in 15 (33%) of the cases, and in all of those, the NCS indicates that an HCP was contacted in eight relating to Kilmarnock, six to Saltcoats and one at Lamlash. Ten of those required medication to be dispensed.

111. We noted a consistent theme where the NCS was updated by staff who recorded the actual medication as *"other"* rather than by its name and there was no indication of what it was. Another issue was that the dispensing frequency was often described as *"as required"* with no specific timing indicated.

112. During our onsite inspection, it was apparent that medication was specifically named on a medical sheet which was passed to custody staff and written clearly on the compliance aid. The dispensing frequency was dictated by the compliance aid, the options being described as *"breakfast, lunch, tea or bedtime"*. The FME filled the aid in such a manner that the medication was issued at one of these stages.

113. One detainee in Arran required a medical referral. The doctor was unable to leave the hospital and consequently officers escorted the detainee to the nearby hospital to see the doctor. This reflects a good partnership relationship that needs to exist in rural communities and is a positive decision.

114. Overall, the recording of medicines on the NCS is poor. There is a reliance upon the compliance aid for accurate information, however these are shredded after use. We suggest that the recording of information in relation to the medical assessment and medication manager pages on the NCS are improved.

Governance of Healthcare

115. NHS Ayrshire and Arran is responsible for the delivery of healthcare in the custody centres in Ayrshire, which includes Kilmarnock and Saltcoats custody centres. The NHS board delivers healthcare through a contracted arrangement with Custody and Offender Medical Services (COMS). The COMS service is peripatetic and therefore not based within a single custody centre. It provides a 24/7 on-call service, with a Forensic Medical Examiner (FME) available. Through funding made available via the national Action 15 Mental Health Strategy,[21] a registered Mental Health Nurse (RMN) or a learning disability Nurse (RLDN) was available between 9-5pm, 6 days a week.

116. FMEs were at full staffing complement and recent recruitment had taken place to the RMN role. Rota's were planned 6 months in advance. Processes were in place at the shift handover for healthcare staff to communicate and share information about any ongoing or outstanding patient care requirements.

117. Healthcare was well managed, with NHS Ayrshire and Arran's COMS service providing a clear management structure, monitoring and oversight through its clinical and care governance processes. Regular multiagency meeting between NHS, COMS and Police Scotland took place to share updates and discuss incidents and complaints.

118. COMS delivered an induction programme for all new healthcare staff. The induction also introduced staff to trauma-informed practice. New staff had the opportunity to shadow colleagues and NHS Ayrshire & Arran had provided training opportunities specific to local operating procedures.

119. Training records showed that the majority of staff were compliant with their mandatory and role specific training. The healthcare team had the opportunity to complete the new national available human rights-based training covering the Istanbul Protocol[22] and applying human rights.

[21] Action 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody centre, and to our prison.
[22] OHCHR, Istanbul Protocol, 29 June 2022.

120. Quarterly peer reviews provided a forum for practitioners to discuss as a team, complex case reviews, and reflect on practice. We were told all FMEs had an annual appraisal which was recorded. The service was developing a system to monitor nursing staff's annual appraisals.

121. There was no clinical supervision in place for nursing staff, though senior FMEs were routinely available for advice and to discuss complex cases. Having regular formal supervision ensures that staff are supported in their reflections of actions they have taken and have the opportunity to discuss their decision-making, especially in more stressful or complicated situations.

Recommendation 3

NHS Ayrshire & Arran should ensure formal and regular clinical supervision is available to all nursing staff.

122. The DATIX (risk management information system) was being used by healthcare staff to record any incidents and adverse events. Incidents were reviewed, with evidence of actions taken recorded and any learning or change to practice shared with healthcare staff via email.

123. Detainees feedback was generally positive about their experience of accessing healthcare with detainees able to describe the process to raise concerns regarding healthcare. At the time of inspection there had been no complaints received in the last 12 months. There was limited information displayed about how detainees could make a complaint or give feedback. However, inspectors were told the service had recently met with NHS Ayrshire and Arran's complaint department to discuss improving the complaints process for police custody in NHS Ayrshire and Arran. It was agreed that leaflets and a poster would be provided for each custody centre to ensure that patients accessing healthcare services have information on how to make a complaint. Leaflets had been provided in each custody centre and up to date posters were in the process of being produced.

124. Treatment rooms in both centres were visibly clean and generally in a good state of repair, with hand wash basins and personal protective equipment (PPE) available for use. Flooring, surfaces and the ceilings were mostly intact ensuring effective cleaning could be carried out. An external cleaning company had access to clean the treatment room. Healthcare staff undertake cleaning of the surfaces and medical equipment after each use in the treatment rooms, however, there was no system in place to record when cleaning had taken place. As this had been identified in a recent infection prevention and control (IPC) audit, senior managers were aware of the requirement to implement cleaning schedules and agreed to do so with immediate effect. An appropriate chlorine-based cleaning product was available in line with current guidance. Cleaning of the cells and custody areas in both centres, including the management of blood or body fluid spillages, was completed by an external company.

125. A range of audits regarding consultation times, harm reduction activity and quality of record keeping were in place. These were undertaken by senior management to monitor practice and drive improvement across the custody healthcare service. COMS produced an annual report reviewing the provision of healthcare delivered with Kilmarnock and Saltcoats custody centres. This included data on healthcare delivery, service development, training, complaints, governance and recommendations for the services future. This is good practice.

126. Sharps bins, which are used to dispose of used needles or sharp medical items, were available in the treatment rooms and at the charge bar. Inspectors found they were not consistently labelled or with temporary closures in place. Clinical waste bins were available and were not overfilled. Police Scotland hold the waste contract with an external company for the collection of clinical waste. NHS Ayrshire and Arran have a separate arrangement for the disposal of sharps and pharmaceutical waste. No linen was used by healthcare staff. Linen used in the custody area was managed by custody staff and was laundered by an external company. Used linen was stored securely while awaiting collection.

Recommendation 4

NHS Ayrshire and Arran and Police Scotland should ensure that sharps bins are managed in line with current guidance.

127. Whilst there was evidence of oversight of IPC in both custody centres, with recent audits having taken place in both centres, there was no identified IPC lead. However, plans were in place to formalise this role. Inspectors were advised that IPC training was not currently monitored as part of mandatory training for healthcare staff. This is important to ensure staff are up to date with current guidance. Appropriate policies and the National Infection Prevention and Control Manual (NIPCM)[23] was available on the staff intranet.

Recommendation 5

Infection prevention and control training should be made available to all healthcare staff.

128. Training records showed that healthcare staff had access to medical emergencies training. At the time of inspection, records showed not all nursing staff had completed this. However, imminent training was planned for those remaining staff to be trained. Custody staff were trained in first aid. Systems and processes were in place for the management of emergency situations including the use of emergency ambulances to take detainees to hospital if necessary. Medical rooms were equipped with essential emergency equipment including oxygen and automated external defibrillators. Emergency equipment was well organised and we were provided with evidence of routine checks being completed. Emergency medications were also available and were seen to be in date.

[23] National Infection Prevention and Control Manual.

Access to healthcare

129. Patient healthcare needs were identified through a vulnerability questionnaire completed by Police Scotland custody staff when people were brought into custody. The information the detainee gives when completing the vulnerability questionnaire may result in a referral being made to healthcare staff. Guidance was available for FMEs to support the triage of referrals they received. Custody staff told us that they generally found FMEs responded quickly to their requests for healthcare reviews. Patients we spoke with told us they were happy with the time they had to wait to see a doctor or a nurse.

130. Detainees could also request to see healthcare staff at any point, patients we spoke with were aware that they could request to see a doctor or nurse at any time. Healthcare and custody staff told us that these requests would always be facilitated. Information regarding healthcare was included in the letter of rights that was routinely given to detainees. Healthcare and police custody staff could access interpretation services to support the vulnerability assessment and ongoing healthcare assessments. Language identification posters were visible in the charge bar area of the custody centres.

131. In both centres, clinical examinations were generally carried out in a dedicated treatment room. Although the door to the treatment room could be closed when an examination was being carried out, healthcare staff informed us that the door was generally kept open with a member of custody staff outside the room for safety reasons. When this cannot be safely achieved, a risk assessment must be carried out with mitigating actions put place. We were told there was generally a verbal risk assessment agreed between the healthcare professional and police custody staff, however no formal risk assessment was in place to support this decision.

Area for improvement 5

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

132. Custody staff use the National Custody System (NCS) to record custody information relevant to detainees, whereas NHS staff use Adastra.[24] These separate electronic systems were unable to connect with each other to share information. Therefore, recommendations and information relating to medications following a patient's assessment were printed off and handed to the custody staff; this information was then copied onto the NCS. However, custody staff told us that the information could also be received electronically and then copied onto the NCS. Police Scotland should consider standardising this approach to reduce the risk of healthcare information being missed or incorrectly recorded when manually copied.

133. Healthcare assessments were recorded on the Adastra system, with a range of standardised assessments available. We reviewed patient records and saw evidence of detailed holistic assessments taking place with associated risk assessments and care plans in place.

134. Staff were aware of the process for identification and documentation of injuries allegedly sustained because of force. While Kilmarnock custody centre had no accessible cells for detainees with mobility issues, there was one accessible cell available at Saltcoats custody centre.

Medicines management

135. The services local operating procedure: Medicines Management within Police Custody Centres, supported staff with the supply, storage, dispensing and the safe destruction of medicines. There was also a pharmacist with responsibility for supporting the governance of medicines management in the custody centres.

136. Medicines including controlled drugs were stored securely in locked cabinets in the treatment room. The keys for the medicine cabinets were kept in a key safe to which only healthcare staff could access.

[24] One advanced, Clinical Patient Management - Adastra.

137. Medications were prescribed by an FME. 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 patients OST from their home address or community pharmacy. Detainees raised no concerns about receiving their medication whilst in custody.

138. Processes were in place for medications to be administered by custody staff from compliance aids, apart from OST, which was administered by an FME. Custody staff were aware of the required patient identity checks that they carried out to ensure the safe administration of medications. Custody staff also received written information from the FME to support safe medicine administration. The compliance aids were held securely by custody staff until they were required. The NCS computer system alerted custody staff when medications were to be administered. We checked several stock medications and found these to be in date with evidence of stock management.

139. We found several areas of concerns on reviewing the controlled drugs registers and the controlled drugs cupboard. There was no recent evidence of the patient's own controlled drugs being recorded in the controlled drug register when stored in the controlled drug cupboard. Furthermore, there was no evidence of the administration and subsequent balance of controlled drugs being recorded in the register. Inspectors could not therefore be assured that controlled drugs were securely and appropriately managed. We saw that some entries in the controlled drug register were not legible with evidence of scoring out and over writing. A formal notification of concerns regarding controlled drugs management was raised with NHS Ayrshire & Arran and the COMS leadership team. We received a letter of assurance outlining recommendations had been sought from the Controlled Drug Officer and we were assured plans were in place to address the concerns raised.

140. Although the frequency of the prescribing of certain medications was monitored, no formal audits to monitor the quality of prescribing were being carried out.

Recommendation 6

NHS Ayrshire and Arran should introduce an audit to assure themselves of the quality of medicine prescribing in the police custody centres.

Recommendation 7

NHS Ayrshire and Arran must ensure effective processes are in place for the recording of controlled medicines to ensure patient safety and compliance with regulatory requirements.

Substance use

141. The vulnerability questionnaire used by custody staff when detainees arrive at custody includes questions regarding the use of substances or whether detainees have substance dependency. FMEs assess detainees who appear to be under the influence or withdrawing from of alcohol or substances. FMEs have access to the appropriate tools for monitoring withdrawals, carrying out physical observations and prescribing medication where required.

142. 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 is not routinely given prior to attending. However, 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.

143. 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. Whist limited progress had been made in Kilmarnock and Saltcoats regarding the implementation of MAT in police custody, inspectors were encouraged to learn that training opportunities had been made available to healthcare staff on MAT. An initial baseline exercise has been undertaken with changes to be put in place once a national agreement is made about what is required to be delivered within police custody settings.

144. BBV testing was available to all detainees accessing healthcare in custody on an opt out basis. All healthcare professionals had access to Naloxone[25] and were trained in using it. Both treatment rooms had information about take-home Naloxone kits. Healthcare professionals were able to train patients to administer Naloxone and provide them with take-home kits. Inspectors were unclear that in the absence of healthcare professionals being onsite, whether police custody staff would administer Naloxone if a detainee needed it. Inspectors were told police sergeants and custody constables were trained and carried Naloxone but not all CJPCSO's were trained to use it.

145. Information was displayed in the treatment rooms on the availability of nicotine replacement therapy (NRT) and a SOP was in place outlining the process for supplying patients with NRT whilst in custody. However, feedback from detainees suggested they were not aware this was available to them.

Recommendation 8

NHS Ayrshire and Arran should improve awareness to detainees and Police Scotland on how nicotine replacement therapy (NRT) can be supplied.

[25] 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.

Mental health

146. During core working hours nursing staff would undertake fitness for release, fitness for detention and a holistic mental health assessment. A standardised assessment tool was available including the patient's history, details of examination and assessment and recommendations. There was evidence of relevant information being shared confidentially with custody staff, where appropriate, in a care plan format. Outwith core hours, FMEs would triage and undertake an initial assessment of patients' mental health if this was indicated.

147. A standardised risk assessment tool was available on Adastra for healthcare staff to identify people at risk of self-harm or suicide. Police custody staff confirmed they received a written care plan from healthcare staff outlining any risk management plans, such as enhanced monitoring or observation levels, where there was a concern for a patient's wellbeing.

148. Delays in accessing secondary mental health assessments[26] can impact on the wellbeing of those detainees' awaiting assessments or admission to hospital. It can also impact on local policing, as it is often the case that police officers are required to transport detainees from custody centres to a hospital for a mental health assessment. Because of delays for secondary mental health assessments for detainees in both custody centres, NHS Ayrshire and Arran were reviewing its secondary care mental health pathway with the aim to improve access times.

149. Custody data showed that Kilmarnock and Saltcoats centres were rarely used as a place of safety under section 297 and 298 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Information for healthcare professionals was visible in the treatment rooms on the pathway and who the key contacts were for referrals to the community mental health team.

150. Detainees with learning disabilities could be identified from the vulnerability questionnaire and systems were in place to involve an appropriate adult service if required.

[26] Secondary mental health involves more specialised services that offer emergency response and planned treatment for individuals with more severe or complex symptoms. Examples of secondary mental health services are hospitals, some psychological wellbeing services, community mental health teams, crisis resolution and home treatment teams, assertive outreach teams and early intervention teams.

Pre-release pathways and referrals

151. When a detainee is moved from a custody centre to another area, for example when going to court, a Person Escort Record (PER) form is completed. This form contains information regarding the detainees medical conditions and medications. Custody staff take this information directly from the custody computer system.

152. In Kilmarnock custody centre there was evidence of signposting detainees to community support services. An extensive list was provided to people on release to take away, listing a range of activity-based mental health, substance use, health & wellbeing, harm reduction, peer support and family support available in the community. We consider this to be good practice.

153. Posters were visible in Saltcoats custody centre signposting detainees to community support services, and they offered information leaflets on alcohol and drug support and community psychiatric nurse (CPN) services. Guidance for healthcare staff regarding onward referrals to community services was seen in the treatment room at Saltcoats. Custody staff were knowledgeable about support available in the community.

154. *'We are With You'*, a charity offering support for people with alcohol, drugs and mental health issues attends the police custody centres every weekend. The charity offers a face-to-face meeting and a signposting and referral service to community support services for all detainees. This is good practice and a proactive example of support to detainees to access appropriate community healthcare.

155. Healthcare staff have processes in place to link in with community pharmacies, community mental health and substance use services where required for continuity of care.

Detainee transfers

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

157. 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.

158. Custody staff at Kilmarnock have a good relationship with GEOAmey staff at the sheriff court, in part because at weekends the police use the court cells. There is an understanding that the police will only occupy the court cells with detainees who are held for Kilmarnock sheriff court and this provides a more seamless handover arrangement on a Monday morning. The sergeant felt that there had been some improvement in the service provided by GEOAmey in the past six months or so.

159. 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.[27]

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

Local policing

160. Inspectors spoke with local police officers and custody supervisors to discuss issues or challenges which can arise. Most concerns raised from local policing relate to disposal decisions. We were advised that there is a live time escalation process with the FCI and CRI which way to deal with this.

161. Officers explained that detainees charged in relation to drugs deaths and drug offences often seem to be reported for summons. The perceived problem with this is that it is taking a considerable period of time for COPFS to progress summons cases and so there is no early intervention to their offending activity. It was explained that an instruction to allow investigation officers to begin the forensic examination of telephones for example, is only issued once the offender has appeared at court and can take a year to begin.

162. A number of officers expressed concern about the loss of custody facilities at Ayr. Detainees who are arrested in South Ayrshire, can now take over an hour to be conveyed to Kilmarnock or Saltcoats. They argued that a custody facility in Ayr is necessary for geographical reasons rather than volume. However, it is noted that this scenario, where rural communities are not generally served by local custody centres, is commonplace across Scotland and the current financial position within policing considerably limits such arrangements.

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