



<b>Meeting</b>	<b>Policing Performance Committee</b>
<b>Date</b>	<b>6 December 2023</b>
<b>Location</b>	<b>Video Conference</b>
<b>Title of Paper</b>	<b>HMICS Custody Inspections- Lanarkshire and Tayside Improvement Plans</b>
<b>Presented By</b>	<b>ACC Wendy Middleton</b>
<b>Recommendation to Members</b>	<b>For Discussion</b>
<b>Appendix Attached</b>	<b>Appendix A – Action Plan – HMICS/HIS Joint Inspection of Police Custody in Lanarkshire</b>  <b>Appendix B – Action Plan – HMICS/HIS Joint Inspection of Police Custody in Tayside</b>

**PURPOSE**

The purpose of this paper is to provide members with an overview of Police Scotland planned improvement activity in response to findings of the recent Custody Inspections of Lanarkshire and Tayside.

Members are invited to discuss the content of this paper.

## 1. BACKGROUND

His Majesty’s Inspectorate of Constabulary in Scotland (HMICS) and Healthcare Improvement Scotland (HIS) conducted a baseline review of the provision of healthcare services to police custody centres across Scotland (January 2023).

The learning from the review has been used to support HIS to develop an interim framework to inspect healthcare services within police custody, and for the scrutiny partners to devise a methodology for the joint inspection of police custody centres.

Primary custody centres in Lanarkshire and Tayside were selected for further localised inspections in order to continue to develop inspection methodology and to complete the inspection framework. The inspections were 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 centre.

HMICS Inspection Reports were published in April 2023 (Lanarkshire) and July 2023 (Tayside).

HMICS outline within these reports, information relevant to the efficiency and effectiveness of custody centre operations.

## 2. FURTHER DETAIL ON THE REPORT TOPIC

### 2.1 Summary of Recommendations and Areas for Improvement-by Themes

#### Lanarkshire Custody

The report contains a total of **15** recommendations of which **9** are for Police Scotland and a total of **7** Areas for Improvement, of which **4** are for Police Scotland.

The themes that have been identified for Police Scotland to address are summarised below: -

Themes	Recommendations
Custody processes	1;3;7
Physical custody environment	2;8;9;13
Training	4;15

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The nine (9) recommendations for Police Scotland are as follows:

- Police Scotland should make arrangements to improve the observation room and its facilities within the police custody centre at Motherwell.
- Police Scotland should ensure that a full evacuation of custody centres is undertaken in accordance with fire safety regulations.
- Police Scotland should ensure that processes for recording cell checks are carried out consistently and recorded on the national custody system timeously.
- 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.
- NHS Lanarkshire, COMS and Police Scotland should record and monitor patient transfers from custody to hospital and produce management reports on the impact of this to inform service planning and delivery.
- Police Scotland should ensure that environmental cleaning standards are maintained within medical rooms in line with clinical standards.
- The custody centres should ensure that suitable cleaning products are available within the centres, which meet the required health and safety standards for the task.
- Police Scotland should ensure that safe and lockable storage is available and used consistently for controlled drugs brought in by detainees.
- Police Scotland should ensure that Naloxone is available within custody centres and that it can be administered during times when healthcare professionals are not available.

Two (2) of the areas for improvement relate to custody processes:

- The custody centre should ensure that property management procedures are followed and implemented effectively.

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- The custody centres should ensure that a clear rationale is recorded on the national custody system in support of risk assessments and changes in observation levels.

Two (2) of the areas for improvement relate to information for detainees:

- NHS Lanarkshire and Police Scotland should work together to ensure that detainees know how to provide feedback or raise a complaint regarding the healthcare service they received while in custody.
- The custody centres should improve the display and availability of information regarding services available in the community to support detainees on release.

### Tayside Custody

The report contains a total of **8** recommendations of which **4** are for Police Scotland and a total of **6** Areas for Improvement, of which **5** are for Police Scotland.

The four (4) recommendations for Police Scotland (1; 2; 3; 8) all relate to Custody Processes.

- Police Scotland should review and amend booking-in processes and facilities at Dundee custody centre to improve the efficiency and effectiveness of the process.
- 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.
- Police Scotland should ensure that the recording of strip searches at Dundee custody centre provides an accurate reflection of practice.
- Police Scotland should collaborate with healthcare providers to ensure that relevant health related information is recorded on detainee's escort records.

The five (5) areas for improvement relate to guidance and processes:

- The custody centre should ensure that property handling guidance and practice is followed to avoid property challenges.

- The custody centre should ensure that all solicitor consultations and interviews with detainees are recorded accurately on the national custody system.
- The custody centre should ensure that all decisions to issue a detainee with anti-harm clothing are well-evidenced and reflective of risks as well as detainee needs and rights.
- The custody centre should ensure that staff use other facilities within the station to maintain the integrity of the food preparation area for people in custody.
- The custody centre should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.

## **2.2 Key Considerations**

This report provides Police Scotland's approach to developing responses to the recommendations and Areas for Improvement identified within these two Custody Inspections.

The Improvement Plan has been developed with engagement of key stakeholders including NHS Boards and the National Police Care Network (NPoCN).

The key considerations that have taken into account when developing improvement actions are outlined below:-

- Alignment with Organisational Strategy
- Desired outcomes
- Milestones that will be used to measure performance
- Strategic/operational/divisional risks
- Responsibilities-Strategic/action owners

Section 2.3 of this report provides more details on the alignment with our Organisational Strategies.

The Improvement Plans attached highlight the Risk/Outcome/Background associated to the recommendation or area improvement, the Management Response/Intended Actions and the Evidential Requirements, along with target dates.

The plans also identify action owners; strategic owner, at ACC level and relevant Police Scotland Internal Governance Board.

Detailed Improvement Plan for **Lanarkshire Custody** is attached at Appendix 'A'.

Detailed Improvement Plan for **Tayside Custody** is attached at Appendix 'B'.

### **2.3 Alignment with Organisational Strategy**

The strategic outcomes provide a clear route from the Scottish Government's outcomes and priorities, including the Justice Strategy, through Police Scotland's strategies, plans and performance reporting, ensuring alignment.

The improvement actions from the Custody Inspections have been considered within the wider policing context of the Strategic Outcomes. The improvement actions aligned to the Police Scotland Strategic Outcomes are highlighted below.

Strategic Outcome(s)	Improvement Actions
Threats to public safety and wellbeing are resolved by a proactive and responsive police service.	Roll-out of Naloxone across the CJSD estate.
The needs of local communities are addressed through effective service delivery.	Introduction of tablet devices in Police Custody for accurate and contemporaneous recording of observations.
The public, communities and partners are engaged, involved and have confidence in policing.	Development of the arrest referral programme to provide support for arrested persons and reduce reoffending.
Our people are supported through a positive working environment, enabling them to serve the public.	Development of custody engagement forums, CPD events and additional training such as Trauma Informed practices training.

Police Scotland is sustainable, adaptable and prepared for future challenges.	Development of the Custody Dashboard to obtain and monitor vital management information.
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## **2.4 Outcomes and Impact**

Where improvement actions are not included in Quarterly Performance Reports, progress will be reported within the wider Improvement Plan updates to the Policing Performance Committee.

## **2.5 Governance and Reporting**

ACC Middleton is the Executive Lead for these Improvement Plans with Chief Superintendent Russell designated SRO.

The Improvement plans were approved by Chief Superintendent Russell on 19 October 2023.

The Improvement Plans will be presented to the next Local Policing Management Board (LPMB) and thereafter forwarded to HMICS.

In consideration of operational priorities, capacity and dependencies of the contributing Divisions/Departments the actions and timescales are considered achievable.

Regular updates will be provided on Improvement Plan progress to LPMB and the SPA Policing Performance Committee:

- (i) key achievements.
- (ii) recommendations closed in the period:- outcomes and impact on service delivery.
- (iii) recommendations in progress:-emerging challenges/risks to delivery and rationale for changes to target dates.

Updates will be provided in accordance with standard reporting arrangements requested by the Committee.

## **2.6 Next Steps**

Significant work has already been completed in relation to the recommendations and areas for improvement from the Lanarkshire and Tayside Inspections and it is anticipated that a number of the actions will be discharged shortly.

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Highlights in relation to the developments include:

CCTV refurbishment is ongoing at Motherwell custody centre, and this has included a review of the CCTV monitoring room. A joint health and safety visit took place in October 2023. Additional storage has been requested to remove items that were previously in this area.

Fire evacuation procedures have been reviewed across the estate and updated guidance has been circulated to include full evacuation of detainees or actors. Full evacuations of the centres at Motherwell and Coatbridge were completed in September 2023.

Tablet devices are now in the majority of centres, allowing contemporaneous recording of custody observations. The use of these tablets was commented upon in the recently published inspection of custody in V Division.

CJSD have recently established a series of quarterly Custody Engagement Forums, providing all custody officers and staff an opportunity to hear important updates and provide suggestions for improvements.

A Custody Dashboard has recently been established, providing vital management information to allow effective monitoring and future planning. Version 2 of the dashboard is due to be published soon.

94% of officers within CJSD have now completed Naloxone training and kits are available in all custody centres. Discussions are ongoing with the trade unions regarding the potential further roll-out to CJPCSOs. Naloxone has been successfully administered within custody on eight occasions.

Protocols regarding Team Leader and Sergeant responsibilities have recently been developed and circulated. A SMARTEU exercise to test the response to a death in custody has also been developed and trialled in Dundee.

There are some areas of challenge which may delay progression of the recommendations (any projected delays are reflected within the action plan target dates).

Any estates development and purchase of additional storage and equipment will need to be considered under the current financial situation and pressures on the estates department, therefore may be subject to delay.

Following a recent resources review, CJSD removed the Audit and Compliance Sergeant posts and therefore the data available in relation to



quality control and compliance auditing has reduced. However weekly Cluster audits have been instigated and are conducted by the Cluster Inspectors meantime, in order to ensure a level of assurance auditing. It is hoped that Version 2 of the Custody Dashboard will provide further assurances.

In relation to the Area for Development related to arrest referrals, CJSD are currently refreshing the arrest referral programme following a requirement from the Information Commissioners Office to move away from consent-based referrals. Until this new pathway for referrals is finalised, this is delaying the introduction of any additional services.

In relation to the better sharing of health information on the prisoner escort forms (PER), discussions are ongoing with partners as this form is not owned by Police Scotland, however all parties have expressed a desire to engage and develop improvements to the process.

### **3. FINANCIAL IMPLICATIONS**

- 3.1 Recommendations 1 and 13 from the Lanarkshire Inspection will require some estates work and the purchase of additional furniture / equipment and will have a minor financial implication.

### **4. PERSONNEL IMPLICATIONS**

- 4.1 There are no personnel implications in this report.

### **5. LEGAL IMPLICATIONS**

- 5.1 There are no legal implications in this report.

### **6. REPUTATIONAL IMPLICATIONS**

- 6.1 There would be reputational implications should the recommendations not be discharged, however there are no anticipated challenges with meeting the requirements of the recommendations or areas of improvement from these inspections.

### **7. SOCIAL IMPLICATIONS**

- 7.1 There are no social implications in this report.

## **8. COMMUNITY IMPACT**

- 8.1 The improvements delivered by these recommendations will undoubtedly improve the service to the public and therefore the communities Police Scotland serves.

## **9. EQUALITIES IMPLICATIONS**

- 9.1 Equality, diversity and human rights feature across each of the recommendations. EqHRIAs will be developed from the outset as new processes are developed.

## **10. ENVIRONMENT IMPLICATIONS**

- 10.1 There are no environmental implications in this report.

### **RECOMMENDATIONS**

Members are invited to discuss the content of this report.

## Appendix A – Action Plan – HMICS/HIS Joint Inspection of Police Custody in Lanarkshire

Lanarkshire Inspection Recommendations	Risk/Outcome/Background	Management Response/Action	Evidential Requirements	Current Target	Status	Timing
<p>R1 - Improve Observation Room + Facilities at Motherwell</p> <p>Police Scotland should make arrangements to improve the observation room and its facilities within the police custody centre at Motherwell.</p>	<p>The custody centres at Motherwell and Coatbridge had a very similar layout and facilities. The general condition of the centres was good, despite them being within an older part of the custody estate. They were clean and reasonably well maintained. Where we saw that some minor repairs could be made, these had mostly been identified by staff and had been highlighted to the maintenance service for attention.</p> <p>We examined the route into the facilities, including the outside parking area / yard, the vehicle dock and holding cells. The electronic gates at both centres were not working at the time of our visit and therefore the yard was not secure. This had been identified by custody staff and the gates had been reported for repair.</p> <p>Vehicle docks were of limited size at both centres and, at most, could accommodate a patrol vehicle or van. These areas were mostly used as an additional layer of security for walking transfers, while police vehicles were parked within the yard. We noted that the parking spaces near to the vehicle docks were occupied with vehicles other than marked police vehicles, including a maintenance van. We would suggest that these areas remain clear and are prioritised for police vehicles bringing people into and out of the custody centre. The vehicle docks had good CCTV coverage.</p> <p>The holding areas in both centres were secure and were fitted with audio and visual recording equipment. They also had a well-positioned affray strip.<sup>16</sup> Holding areas were visible from the charge bar.</p> <p>Each custody centre had two charge bars, with one being larger and better situated than the other. Although these were side by side, the second of the two charge bars were smaller, and the adjacent space was used as a route from the staff office to the custody cell area. There was no partition between the charge bars and space was limited. Were both charge bars to be used at the same time, privacy would be reduced and due to limited space, it would be challenging to conduct any necessary searches safely.</p>	<p>The inner custody secure gate is in working order at both locations. The exterior gates of the police station are now working at Coatbridge but not currently at Motherwell however it has been reported. The parking spaces closest to custody are all police vehicle bays with messaging of this instruction sent to all relevant departments within the police station.</p> <p>Both charge bars have partitions separating the two charge bars, there is not an additional partition between the second charge bar and the walk through area from the custody office to the cell complex however only authorised personal will be within this area and through traffic is minimised during processing times.</p> <p>The lighting within the CCTV viewing room at</p>	<p>Results of the H&amp;S audit and confirmation of any works being completed.</p>	<p>31/03/2024</p>	<p>Draft</p>	<p>20/04/2023</p>

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	<p>In general, the custody centres had limited space and limited capacity for modification. The staff office at Motherwell was cramped and the signage and guides on the office walls had become cluttered. Whilst this would be unlikely to pose difficulties for long serving staff, it could be challenging for new staff or those covering shifts.</p> <p>The CCTV observation room at Motherwell was not well laid out. It was dimly lit and warm which, coupled with non-adjustable lounge style seats, may invite alertness challenges for officers engaged in longer deployments. The screen display resolution on monitors was also poor. The observation room at the Coatbridge centre was better.</p>	<p>Motherwell is on a dimmer switch and can be turned up or down depending on the preference of the person conducting observations. Consideration will be given to purchasing additional lamps for use within the room.</p> <p>Review of the layout with Estates is being incorporated into the CCTV refurbishment works which are ongoing at Motherwell only at this time.</p> <p>Additional storage has also been requested for the centre to remove boxes which were held in this area.</p> <p>A joint Health and safety visit with staff associations for both Coatbridge and Motherwell is took place on 24/10/2023 and the seating within the CCTV viewing room was reviewed for appropriateness during this visit</p>				
<p>R2 - Compliance with Fire Safety Regulations (Full Evacuations)</p> <p>Police Scotland should ensure that a full evacuation of custody centres is undertaken in accordance with fire safety regulations.</p>	<p>There was multiple clearly marked emergency exits covering all areas within the footprint. Fire safety precautions and procedures were taking place routinely. Whilst fire tests were being carried out regularly, these did not include the physical evacuation of detainees. An evacuation of custody centres, including detainees, is expected to be</p>	<p>Fire evacuation procedures have been reviewed across the CJS estate and updated guidance has been circulated.</p>	<p>Copy of the updated guidance.</p> <p>Confirmation of the full</p>	<p>31/01/2024</p>	<p>Draft</p>	<p>20/04/2023</p>

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	<p>carried out in accordance with fire safety regulations. The custody centre has the autonomy to decide when it is suitable to do this based on an assessment of risk and the needs of the detainees in custody at any given time.</p>	<p>Full fire evacuations were conducted for both Motherwell and Coatbridge during September.</p> <p>During these evacuations it was noted that there was no EVAC Sleds - order has therefore been submitted.</p>	<p>evacuations from September.</p>			
<p>R3 - Recording Cell Checks</p> <p>Police Scotland should ensure that processes for recording cell checks are carried out consistently and recorded on the national custody system timeously.</p>	<p>The majority (58%), of detainees were on observation levels 1 and 2; 27% required constant observations via CCTV, and 15% required close proximity observations at level 4. Our analysis concluded that the observation levels selected by custody staff corresponded well to risks identified through the assessment process. This outcome provided us with reassurance that custody staff were making the correct decisions in respect of observation levels in the majority of cases.</p> <p>It should be noted that custody staff undertake the aforementioned assessments often in the absence of support from a healthcare professional as medically qualified staff are not based within the centres. Custody staff told inspectors that they contact the on-call forensic physician service for advice or to request attendance in some circumstances.</p>	<p>Additional briefings have been conducted with staff to ensure that observations are being recorded timeously.</p> <p>The roll out of tablet devices in custody centres to allow checks to be recorded at the time is ongoing and work is ongoing to ensure these are fully embedded and utilised within all our centres.</p> <p>Weekly Cluster audits have recently been instigated and include a review of the recording of observation visits, with no issues having been identified so far.</p>	<p>Copy of briefings and guidance issued to staff on recording of observation visits and the use of tablet devices.</p> <p>Evidence of Cluster audits.</p>	31/03/2024	Draft	20/04/2023
<p>R4 - Custody Staff - Regular Training Updates</p> <p>Police Scotland should ensure that custody staff receive regular custody update training / awareness raising relating to substance abuse issues, mental</p>	<p>Custody staff had undertaken a standard custody centre training course, which included officer safety and ICT training. This provided staff with the knowledge and skills to undertake custody centre duties including the observation of detainees in accordance with the aforementioned levels identified through risk assessment. For</p>	<p>All Custody officers and staff are now completing the Trauma Informed training package</p>	<p>Evidence of completion rates for Trauma Informed</p>	31/03/2024	Draft	20/04/2023

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<p>health, trauma informed care and undertaking detainee observations.</p>	<p>some custody staff, this training was long-standing, and had not been refreshed throughout their time in the role. Whilst we found custody staff to be confident and competent in their role, we identified gaps in the provision of more recent training / awareness raising inputs.</p> <p>Custody staff informed us that they had not undertaken any additional specialist training relating to the particular vulnerabilities common to detainees. This included, for example, training relating to substance abuse issues, mental health, learning difficulty, hidden disability, trauma informed care and moving and handling. Staff indicated that they had received basic guidance on undertaking physical observations regarding detainee alertness / level of consciousness during cell checks but would benefit from additional instruction.</p>	<p>created by NES. As this is an external training package, work is ongoing to establish a means to record this on SCOPE and monitor completion.</p> <p>The Officer Safety Training Courses have recommenced following postponement during COVID and are now completed over 2 days and include face to face first aid training. Work is ongoing to trial an OST CPD course specific to custody, which would be completed over and above the annual refresher.</p> <p>CJSD Training are currently developing a CPD course that will be delivered to all Custody Officers and Staff.</p> <p>We have recently developed quarterly Custody Operations Engagement Forums, which include awareness raising for any current issues and ensure staff remain informed.</p>	<p>Training Package.</p> <p>Evidence of attendance on OST and CPD courses.</p> <p>Evidence of attendance at Engagement Forums.</p> <p>Outcome of trial OST COD course</p> <p>CPD course content</p> <p>Evidence of the impact/outcome of the Custody Operations Engagement Forum</p>			
<p>R7 - Record Patient Transfers</p> <p>NHS Lanarkshire, COMS and Police Scotland should</p>	<p>It is clear therefore, that NHS procedures, which could provide an insight into the quality of the delivery of care, such as complaints procedures, patient feedback and adverse events reporting, were not</p>	<p>A Custody Dashboard has recently been developed to assist</p>	<p>Evidence of the updated dashboard and</p>	<p>31/03/2024</p>	<p>Draft</p>	<p>20/04/2023</p>

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<p>record and monitor patient transfers from custody to hospital and produce management reports on the impact of this to inform service planning and delivery.</p>	<p>being reported. This limits the potential for service providers to analyse and learn from these and to form a comprehensive assessment of the quality of the healthcare provided to detainees.</p> <p>Inspectors noted that prior to a person arriving at the custody centres, custody staff made an initial assessment of healthcare needs based on information available from electronic records and, in some circumstances, from local policing. Where it is identified that a person has significant healthcare needs, such as a physical injury, they would be taken directly to hospital for assessment and then transferred to the custody centre when deemed fit. In circumstances where it is less clear that hospital treatment may be required, the individual is brought to custody for assessment.</p> <p>Custody staff informed us that it can, at times, be difficult to make such assessments in the absence of onsite healthcare professionals. They suggested that this can lead to decisions being made to transfer a detainee to a hospital accident and emergency (A&amp;E) department for assessment rather than to await the arrival of an on-call healthcare professional. This was particularly the case when a person was brought into custody at night.</p> <p>This has the potential to extend the length of time that a person is in custody, particularly should they be assessed as not requiring treatment following a potentially long wait at A&amp;E. It also impacts on local policing, in terms of officers being unable to carry out other duties, as they are required to remain at hospital with the detainee and return them to custody. Similarly, this can add to the burden on A&amp;E staff who must assess the individual. There is no current process in place to collect information on hospital transfers from custody and to measure the impact on services and detainees.</p>	<p>with the gathering of management information. ICT are currently working on enhancements to this dashboard, including the reporting of medical assessments and hospital escorts.</p>	<p>management reports available.</p>			
<p>R8 - Compliance with Environmental Cleaning Standards</p> <p>Police Scotland should ensure that environmental cleaning standards are maintained within medical rooms in line with clinical standards.</p>	<p>Each of the custody centres had a medical room for COMS staff to undertake consultations and provide treatment to detainees as required. We inspected the medical rooms at both centre and found them to be generally in a good state of repair and visibly clean. However, the medical room at Coatbridge had some damage to walls and debris in the corners of the floors highlighting that cleaning was not to the required standard.</p>	<p>As per the MOU, the medical rooms are cleaned once per day. A meeting will be arranged with the cleaning contractor to ensure they are aware of the cleaning standards required for a medical room and</p>	<p>Evidence of regular monitoring and any compliance issues raised with the cleaning contractor.</p>	<p>31/03/2024</p>	<p>Draft</p>	<p>20/04/2023</p>

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		this will be monitored to ensure compliance.				
<p>R9 - Availability of Cleaning Products</p> <p>The custody centres should ensure that suitable cleaning products are available within the centres which meet the required health and safety standards for the task.</p>	<p>Each of the custody centres had a medical room for COMS staff to undertake consultations and provide treatment to detainees as required. We inspected the medical rooms at both centre and found them to be generally in a good state of repair and visibly clean. However, the medical room at Coatbridge had some damage to walls and debris in the corners of the floors highlighting that cleaning was not to the required standard.</p> <p>In relation to more general cleaning standards, we were informed that there were no easily accessible products available for the immediate management for body fluid spillages. Cleaning staff told inspectors that a generic product would be used to clean spillages rather than a chlorine-based product.</p>	<p>It has been established that whilst Chlorine based products were previously ordered, they had been incorrectly returned by cleaning staff due to a misunderstanding of the requirements for managing body fluid spillages. This has been raised with Estates and the Cleaning Contractor and training will be provided.</p>	<p>Evidence of any training provided and of the ordering of Chlorine based products.</p>	31/03/2024	Draft	20/04/2023
<p>R13 - Safe/Lockable Storage for Drugs</p> <p>Police Scotland should ensure that safe and lockable storage is available and used consistently for controlled drugs brought in by detainees.</p>	<p>Whilst there was lockable storage within the custody centres that could be used to safely store controlled drugs brought into custody by detainees, this was not being utilised consistently. Controlled drugs should be stored securely until they can be examined by a forensic physician.</p>	<p>Processes in relation to the storage of controlled drugs are currently being reviewed nationally, alongside NHS Boards applications for the appropriate licences. Updated briefings will be circulated and compliance monitored.</p>	<p>Evidence of briefings and compliance testing.</p>	31/03/2024	Draft	20/04/2023
<p>R15 - Naloxone in Custody Centres</p> <p>Police Scotland should ensure that Naloxone is available within custody centres and that it can be administered during times when healthcare professionals are not available.</p>	<p>Medical rooms contained information to advise COMS staff on issues relating to the use and administration of Naloxone, which was available to healthcare professionals when they were in attendance at the centres. As stated within this report, healthcare staff were not based within the centres and were therefore not immediately available should the need to administer Naloxone arise. Should such an emergency situation occur, custody staff are required to call an ambulance. This could impact on the detainee's health due to an inherent delay in them receiving treatment.</p>	<p>All police officers within Custody have now completed the Naloxone training and have been issued with kits. Naloxone has been administered by staff within custody on 8 occasions, with a successful outcome on all occasions.</p> <p>Work is ongoing with</p>	<p>Evidence of the number of staff who have completed the training and been issued the kits.</p> <p>Evidence of the use of Naloxone within the custody setting.</p>	31/03/2024	Draft	20/04/2023



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		the trade unions in an effort to also have Naloxone issued to CJPCSOs.	Outcome of TU engagement			
<p>Areas for Development</p> <p>The custody centres should ensure that property management procedures are followed and implemented effectively.</p> <p>The custody centres should ensure that a clear rationale is recorded on the national custody system in support of risk assessments and changes in observation levels.</p> <p>NHS Lanarkshire and Police Scotland should work together to ensure that detainees know how to provide feedback or raise a complaint regarding the healthcare service they received while in custody.</p> <p>NHS Lanarkshire should ensure that health-specific information is provided to all detainees regarding the type of healthcare support and treatment available to them while in custody.</p> <p>NHS Lanarkshire and COMS should provide support to staff to enable them to prepare for implementation of the MAT standards.</p> <p>NHS Lanarkshire and COMS should offer nicotine replacement therapy to detainees who smoke in order to support their healthcare.</p> <p>The custody centres should improve the display and availability</p>	<p>We noted that some aspects of detainee property management could be improved. For example, property stores were not locked routinely and in one instance, cash was not counted in front of the detainee. This could potentially result in complaints. Whilst CCTV and audio equipment is installed at charge bars, which provides some protection for custody staff and detainees, we suggest that property procedures should be followed more stringently.</p> <p>We found that vulnerability questionnaires had been completed in all relevant cases within our sample. We consider almost all of these assessments to be accurate based on available information. There were some gaps in the recording of a rationale for decisions on vulnerability. Similarly, the observation level for some detainees had been reduced with no record of the rationale to support the decision.</p> <p>In the past 12 months, there were no records of complaints being raised, not feedback provided, by detainees regarding their experience of healthcare whilst in custody. We found no information available to detainees to inform them about how to provide feedback or raise a complaint regarding their healthcare.</p> <p>During the pre-release risk assessment process, there is an opportunity for detainees to be referred to other agencies for support. Both custody centres had a list of services available within the community to support detainees on release. We also noted that custody officers provided information to people when they were being booked into custody regarding potential supports that were available to them.</p> <p>The availability of support services varies across the country and therefore custody centres can be limited in terms of options for people leaving custody, The Lanarkshire custody centres had engaged with local authority Health and Social Care Partnerships and third sector organisations in order to identify services that could be provided to detainees on release.</p> <p>We noted that South Lanarkshire Alcohol and Drug partnership had entered into an agreement with SACRO for the provision of a new service to support people living in South Lanarkshire who have found themselves in the criminal justice system because of their relationship with alcohol or drugs. Staff from SACRO were available to attend the Motherwell custody centre to meet with detainees every morning</p>	<p>Briefings have been circulated as reminders for the first three areas of improvement for Police Scotland.</p> <p>Work is currently ongoing in relation to arrest referrals and signposting for support, based on concerns raised by the ICO in relation to the use of consent. Once this is resolved it is planned to have a relaunch of the arrest referral scheme to enhance opportunities for support. We are currently exploring the purchase of video brochures, which could be used to display information on support agencies available in each area.</p>	<p>Copies of the briefings.</p> <p>Evidence of the arrest referral relaunch</p>	30/06/2024	Draft	20/04/2023

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<p>of information regarding services available in the community to support detainees on release.</p>	<p>from Sunday to Friday. The custody centres were liaising with another third sector provider, Phoenix Futures, to introduce a similar provision for people living in North Lanarkshire.</p> <p>Whilst custody staff were making referrals to the service, senior managers informed us that the engagement rate following release from custody was low. SACRO is working with Alcohol and Drug Partnerships in North and South Lanarkshire to review how they could improve engagement levels and support people in the treatment for their substance use.</p> <p>We saw limited signage on display within the custody centre to provide people with information on support services available to them.</p>					
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**Appendix B – Action Plan – HMICS/HIS Joint Inspection of Police Custody in Tayside**

Tayside Inspection Recommendations	Background	Management Response/Action	Evidential Requirements	Current Target	Status	Timing
<p>Recommendation 1 Police Scotland should review and amend booking-in processes and facilities at Dundee custody centre to improve the efficiency and effectiveness of the process.</p>	<p>We noted issues affecting the efficiency of the booking-in process including those involving arresting officers as well as the layout of the facility, existing processes and staff practice. Upon arrival at the centre, an arresting officer is required to leave their colleague with the detainee, either in the holding room or in a police vehicle, in order to attend at the custody office to complete a form with information required for the booking in. The officer would then attend at the custody sergeant’s office to discuss the circumstances of the arrest. This process appeared time consuming and resulted in detainees waiting with just one officer for an additional period. We assessed the average waiting time relevant to the booking-in process during our review of NCS records. We reviewed 40 of the initial sample of 42 records as two detainees had been transferred to hospital on arrival. Of those reviewed, the average wait time was 35 minutes, which is longer than the national average (wait time was taken as being between the arrival time and the authorisation time recorded on the NCS). This is the period before which the booking-in process can begin. Booking in of detainees was primarily conducted by CJPCSOs and, in some cases, the constable who had carried out the initial background checks. In order to access systems, it was necessary for custody staff to log off from their terminal in the main office and then log in to a computer at the charge bar to carry out the booking-in process. Custody staff would then create the custody record by pre-populating information gathered on the required form before calling the detainee forward. This process of logging in and out of systems appeared to create unnecessary delays. Custody sergeants and CJPCSO team leaders essentially occupied the same ranking level in terms of authority and chain of command. Both have supervisory responsibility for staff and report to the Cluster Inspector. In terms of function, sergeants make the required criminal justice decisions and team leaders have responsibility for the care and welfare of detainees though in the absence of a team leader, the sergeant carries this responsibility. As a result of the aforementioned split-level custody centre arrangements, we found that CJPCSOs and custody PCs working within the cell block were supervised by the team leader while custody sergeants, based next to the custody office, supervised the staff working upstairs. During our inspection, there appeared to be limited interaction between supervisors, however we were assured</p>	<p>Work is ongoing with ICT to remove unused applications from the booking in computers in order to speed up processing.</p> <p>An end-to-end review of booking in processes will be conducted at Dundee to establish any other opportunities for improving the efficiency, taking account of the limitations caused by the layout of the facility.</p>	<p>Results of end-to-end booking in process review and plans for improvement</p>	<p>30/06/2024</p>	<p>Draft</p>	<p>OnTrack</p>

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	<p>those regular conversations between supervisors took place routinely during shifts. Custody sergeants would routinely approve the initial risk assessment made by custody staff prior to a detainee being escorted to the basement level cells. Information relevant to this is shared between supervisors via radio or telephone. Inspectors noted that investigating officers were required to take the care sheet, which has the observation level stated on it, with them from the charge bar to the cell area, when lodging a person into custody.</p>					
<p>Recommendation 2 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.</p>	<p>We spoke with sergeants and team leaders (referred to in this report as custody supervisors) about their respective roles and responsibilities in relation to the operation of the custody centre. We found that custody supervisors were clear about the distinction between their responsibilities in relation to decisions on criminal justice matters and the care and welfare of detainees. However, they were less clear regarding the lines of responsibility for the management of risk. Should, for example, an incident occurs that results in serious harm to a detainee, the lines of accountability for sergeants and team leaders were not clearly defined. We consider that the Criminal Justice Services Division should give further consideration to this issue in order to ensure that, should an adverse incident occur resulting in serious harm to a detainee, clear lines of accountability are in place for sergeants and team leaders.</p>	<p>Protocols outlining responsibilities have been developed and published. This includes a number of joint responsibilities as CJPCSO Team Leaders are deemed to be of equivalent rank to Sergeant and carry a number of the same responsibilities.</p> <p>In relation to adverse incidents, a tabletop exercise has been developed by SMARTEU and trialled in Dundee, which will allow officers and staff to run a death in custody scenario to understand their roles and responsibilities.</p>	<p>Copies of protocols Evidence of improved understanding of roles/responsibilities Results and learning from SMARTEU exercise</p>	<p>31/03/2024</p>	<p>Draft</p>	<p>OnTrack</p>

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<p>Recommendation 3 Police Scotland should ensure that the recording of strip searches at Dundee custody centre provides an accurate reflection of practice.</p>	<p>All detainees were the subject of a standard search at the charge bar by investigating officers. A handheld metal detector wand and Ampel Probes (large tweezers) were available and were used as required. These searches were conducted respectfully and were compliant with relevant standards. There was, however, no private room on the ground floor within which to conduct a strip search. In circumstances where a strip search had been authorised, the detainee required to be escorted downstairs to the cell block for the search to be completed. As a result of national custody system requirements, it was then incumbent upon custody staff working downstairs to retrospectively amend the search category on the system and include the authorising sergeant's name. We found that this was not being undertaken consistently resulting in gaps in NCS records regarding searches. This meant that in some cases, it was not clear what type of search had been conducted or if indeed a search had taken place.</p>	<p>Updated guidance will be circulated reminding staff of their responsibilities for recording strip searches.</p> <p>Weekly Cluster Audits have recently been established and these will include checks for compliance in terms of search recording.</p>	<p>Copy of updated guidance and evidence of communications. Results of weekly cluster audits and compliance checks.</p>	<p>31/03/2024</p>	<p>Draft</p>	<p>OnTrack</p>
<p>Recommendation 8 Police Scotland should collaborate with healthcare providers to ensure that relevant health related information is recorded on detainee's escort records</p>	<p>Personal Escort Record (PER) form is completed by custody staff. At the Dundee custody centre, these did not always contain full and detailed information regarding detainee health issues that may potentially be relevant to transport service providers. Custody staff took this information directly from NCS; however healthcare staff would invariably provide verbal updates to custody staff rather than a written record regarding medical matters thus leaving gaps in the handover of potentially valuable information.</p>	<p>A review is currently ongoing with partners including CJ Social Work, Geoamey and SPS to improve the quality of information on the PER form and include vulnerability information that will assist CJSW in supporting persons following appearance at court.</p>	<p>Results of review. Evidence of improved recording of vulnerability on PER form</p>	<p>30/06/2024</p>	<p>Draft</p>	<p>OnTrack</p>

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<p>Areas for Development</p> <p>The custody centre should ensure that property handling guidance and practice is followed to avoid property challenges.</p> <p>The custody centre should ensure that all solicitor consultations and interviews with detainees are recorded accurately on the national custody system.</p> <p>The custody centre should ensure that all decisions to issue a detainee with anti-harm clothing are well-evidenced and reflective of risks as well as detainee needs and rights.</p> <p>The custody centre should ensure that staff use other facilities within the station to maintain the integrity of the food preparation area for people in custody..</p> <p>The custody centre should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.</p>	<p>Detainees’ property was stored in an open plastic container behind the charge bar and a white board was updated to cross reference the container number with the detainee. Whilst there was good quality CCTV coverage of the charge bar, the process of not recording and securing property in the presence of a detainee increases the potential for a complaint to be made.</p> <p>We noted that in a few instances, where consultation with a solicitor was requested prior to interview, there was no satisfactory update on the NCS to explain whether a consultation had occurred or if a solicitor had attended. Whilst we anticipate that this was most likely to be a recording issue rather than a gap in solicitor contact, consultations and interviews that take place with detainees should be recorded by populating the custody contact and custody movement pages on the national custody system</p> <p>Whilst the consistent use of risk assessment processes underpin the decision to issue a detainee with anti-harm clothing, we found that the practice had become more routine in some circumstances as supervisors opted for anti-harm clothing as a risk mitigation option. We noted that this was the case in circumstances where the identified risk of self-harm or suicide was historical. We consider this to be an issue for ongoing consideration by the custody centre to ensure that decisions are well-evidenced and reflective of risks as well as detainee needs and rights.</p> <p>The kitchen, although intended for sole use as a custody food preparation area, was being used by staff for personal food preparation thus presenting potential food safety / cross contamination hazards. This was acknowledged by custody supervisors and was noted for further consideration and action.</p> <p>Clinical examinations were carried out in a dedicated medical room. The door was generally kept open with a member of custody staff outside the room. This was highlighted as being for safety and security reasons, unless the examination was of an intimate nature. Where a risk assessment has identified risk then this is of course considered to be acceptable. However, custody staff should consider individual circumstances to a greater extent in order to ensure that, wherever possible, detainees are able to meet with an HCP for assessments and other health related interventions in privacy and therefore maintaining their confidentiality.</p>	<p>Briefings and guidance will be issued for each of the matters raised as Areas for Development. Report progress on the AFD's to SPA Policing Performance Committee.</p>	<p>Copies of briefings and guidance. Copies of reports to SPA PPC</p>	<p>31/03/2024</p>	<p>Draft</p>	<p>OnTrack</p>
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