HMICS Improving Policing Across Scotland

Healthcare Improvement Scotland

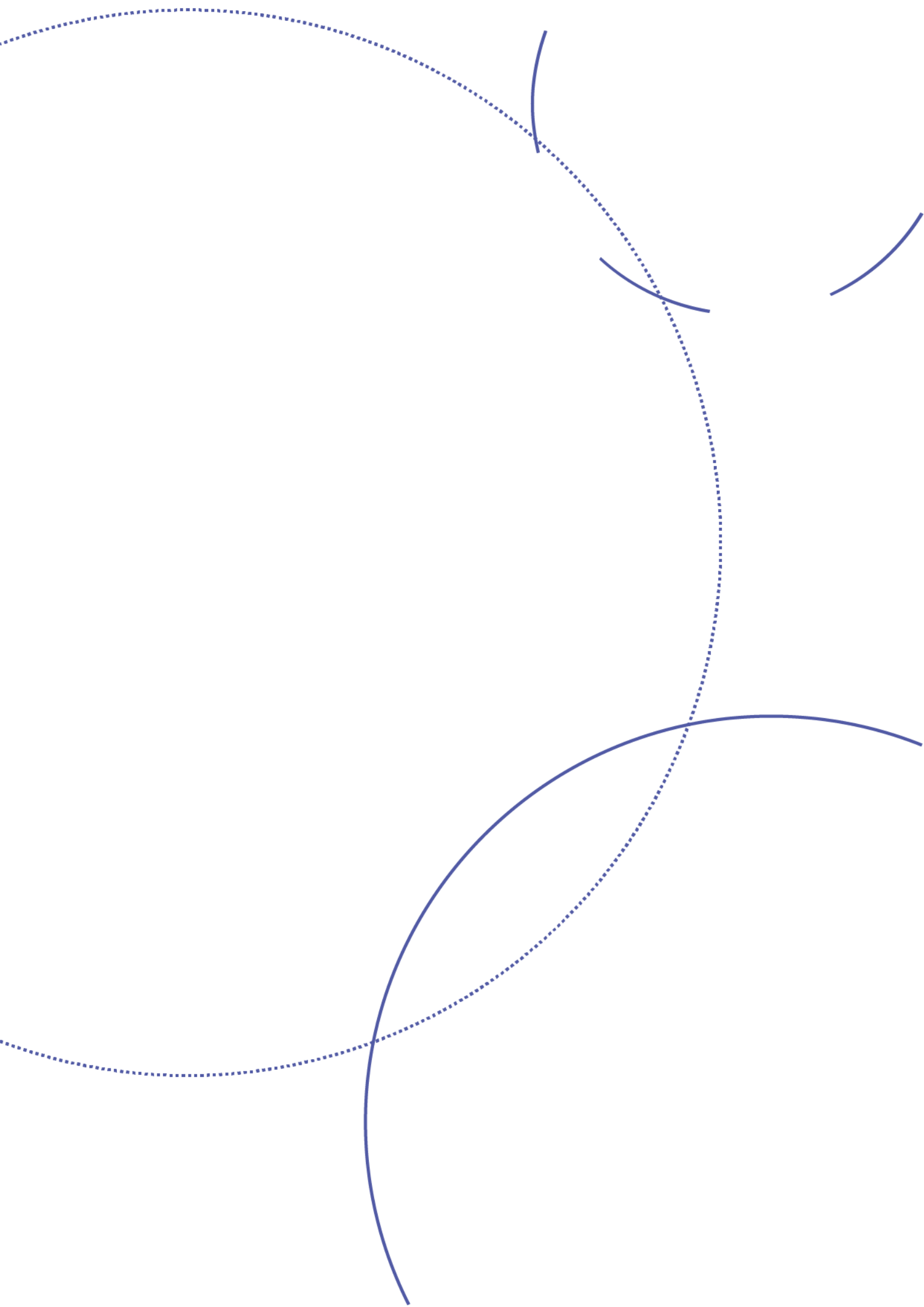
Custody progress inspection report

Argyll and West Dunbartonshire

July 2025

EFQM

npm national preventive mechanism



HM Inspectorate of Constabulary in Scotland

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

HMICS has a statutory duty to inquire into the arrangements made by the Chief Constable and the SPA to meet their obligations in terms of best value and continuous improvement. If necessary, it can be directed by Scottish Ministers to inspect anything relating to the SPA or Police Scotland as they consider appropriate.

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

Places of detention, including police custody centres within the UK, are monitored as part of the human rights treaty: 'Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT)'. 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 and are underpinned by the joint HIS and HMICS Framework to Inspect that ensures a consistent, objective and human rights-based approach to the collaborative work.

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

Contents

Our inspection

In May 2024, a joint custody inspection was undertaken by HMICS and HIS in the Argyll and West Dunbartonshire region, focusing primarily on the custody centres in Clydebank and Oban. Findings from the inspection were published in October 2024 and can be viewed on the HMICS website.

During the inspection, HIS inspectors identified a key area of concern which related to the absence of clinical governance and oversight structures for healthcare provision within Oban police custody centre. HIS communicated these concerns to the Argyll and Bute Health and Social Care Partnership (HSCP), which has responsibility for healthcare provision within the police custody centre in Oban. This was in accordance with an escalation protocol put in place by the scrutiny bodies to respond to concerns identified during a joint custody inspection.

As part of the escalation process, the HSCP were asked to undertake a review of the issues identified and provide a formal update within two weeks of the date of the inspection. The HSCP formal update was subsequently submitted and reviewed by inspectors. Thereafter, a request was made for an action plan to be provided in advance of a pre-arranged visit to the custody centre in order for inspectors to examine the extent to which progress had been made.

The progress inspection took place on 18 March 2025. Inspectors were clear that the purpose of the visit was to focus on the healthcare improvement action plan, with an emphasis on governance arrangements, as well as consideration being given to some of the other healthcare related recommendations made in our initial report.

This report details our findings from the progress inspection undertaken at the custody centre and outlines our evaluation of the remedial measures undertaken by the HSCP in response to the concerns raised within the initial inspection report.

Craig Naylor
His Majesty's Chief Inspector of Constabulary
July 2025

Progress inspection recommendations

Progress inspection recommendation 1

Argyll and Bute HSCP should establish a monitoring framework to ensure that patients' needs are met, and to collect data on patient outcomes in police custody.

Progress inspection recommendation 2

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

Progress inspection recommendation 3

Argyll and Bute HSCP should comply with Health Protection Scotland's NIPCM[1] standard infection control precautions to ensure patient and healthcare staff safety.

Progress inspection recommendation 4

Argyll and Bute HSCP should ensure that checks on emergency equipment and medications are carried out and consistently recorded to ensure that all equipment is within date and ready for use.

Progress inspection recommendation 5

Argyll and Bute HSCP should ensure that full medical assessments are not shared with custody staff. To protect patient confidentiality, only recommendations and guidance essential for patient safety should be given to custody staff.

[1] Health Protection Scotland's National Infection Prevention and Control Manual (NIPCM).

How we carried out the inspection

1. We provided the Argyll and Bute HSCP with advance notice of our planned visit to the Oban custody centre and identified that the following recommendations, drawn from the joint custody inspection report published in October 2024, would form the basis for the progress inspection and subsequent report:

Recommendation 5	Argyll and Bute HSCP must ensure effective governance systems are in place to provide oversight of healthcare delivery within Oban police custody centre.
Recommendation 7	Argyll and Bute HSCP should ensure that any paper patient records are stored securely so that only healthcare staff can access them.
Recommendation 10	Argyll and Bute HSCP should comply with Health Protection Scotland's NIPCM standard infection control precautions to ensure patient and healthcare staff safety.
Recommendation 12	Argyll and Bute HSCP should implement systems and processes to support healthcare and police custody staff in managing emergency situations.
Recommendation 13	Argyll and Bute HSCP should review its process for sharing healthcare information on patients with custody staff.
Recommendation 15	Argyll and Bute HSCP should have approved processes in place to support the delivery of consistent evidence-based care including the management of patients withdrawing from alcohol or other substances.
Recommendation 18	Argyll and Bute HSCP should ensure standardised risk assessments are available to all healthcare staff, and these are completed consistently where required.

2. The progress inspection was undertaken by inspectors from HIS and HMICS who visited Oban custody centre on 18 March 2025.

3. During our follow-up visit to the centre, HIS inspectors spoke with custody staff and members of staff providing healthcare. We inspected the care environment in relation to infection prevention and control and reviewed evidence provided on site. We also held a teleconference with senior managers following the site visit to help inform our inspection findings.

4. While we acknowledge that Argyll and Bute HSCP have made some improvements to address our previous recommendations, our follow-up visit has resulted in additional recommendations being made, which will need to be progressed to ensure continued improvement.

Progress inspection findings

5. During the inspection in May 2024, we were concerned at the lack of established structures and processes in place to provide assurance of clinical and care governance of police custody healthcare delivery within Oban police custody centre. This included a lack of regular meetings between the HSCP and Police Scotland to discuss police custody healthcare.

6. During the progress inspection, we were pleased to see that this had now been addressed and there was evidence of a clear governance structure and reporting process in place. This structure and reporting process also provided assurance to the NHS Highland Integration Joint Board (IJB), that recommendations and concerns from the May 2024 inspection were being progressed. A steering group had been established to address the recommendations and concerns raised in our initial report.

7. A representative from Police Scotland with responsibility for Oban custody centre was a member of the steering group. Priority had been given to developing operating procedures and training for Forensic Medical Examiners (FME) working within the custody centre and that there had been significant work undertaken. During this inspection we saw that an Oban Forensic Medical Examiner Information, Pathways and Resources pack had been developed and that training resources, policies and guidelines were now in place, and were easily accessible electronically.

8. Despite the progress made by the HSCP in clinical care governance, there is still potential for further improvements. Measuring outcomes is challenging across all areas, particularly due to the transient nature of the population in police custody. However, the HSCP needs to gather more robust evidence of local population needs, for example, the type of healthcare intervention required by detainees, the frequency of referrals for healthcare, including the number of people transferred to hospital. This will help to support, design and deliver healthcare services. The lack of this evidence limits the ability to develop and implement plans that effectively meet identified needs and measure outcomes for people in custody.

New recommendations

9. From analysis of the action plan and discussions with the HSCP, it is evident that several areas for improvement have been highlighted. This has resulted in the creation of five additional recommendations as noted below, some of which are continuations of previous recommendations from the report published in October 2024.

10. There is a recognised need to enhance how services capture and report healthcare data and key performance indicators within the context of police custody.

Progress inspection recommendation 1

Argyll and Bute HSCP should establish a monitoring framework to ensure that patients' needs are met, and to collect data on patient outcomes in police custody.

11. Recommendation 7 from the previous report stated:

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

12. During the inspection in May 2024, we found historical and current patient records stored in a locked cupboard in the consultation room. We were concerned that these patient records were not stored securely as non-healthcare staff had access to the consultation room and the keys for this cupboard. The HSCP has since received advice from NHS Highland's data protection officer to ensure that any paper records are managed in line with NHS Highland's Records Management policy. During this inspection, all paper records (apart from those from January 2025 to the present) had been moved to the GP surgery to be securely stored.

13. Although the remaining paper records were stored in a locked cupboard, it was concerning to hear that non-healthcare staff still had access to keys for this cupboard. We therefore do not consider Recommendation 7 from our initial report to have been fully addressed. This recommendation will therefore be carried forward as follows.

Progress inspection recommendation 2

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

14. Recommendation 10 from the previous report stated:

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

15. Following the inspection in May 2024, we made recommendations relating to the environment, compliance with standard infection control precautions (SICPs) and ensuring systems and processes were in place to monitor infection prevention and control practices. It was therefore encouraging to hear that since the inspection, an external IPC audit of the treatment room had been completed by NHS Highland. We were provided with a copy of the audit as evidence. However, not all elements of SICPs were fully implemented during this inspection. This included:

- Sharps bins used to dispose of used needles or sharp medical items were not correctly labelled or had the temporary closures in place.
- Personal Protective Equipment (PPE) not stored appropriately.
- The biohazard bin did not have correctly fitting lid.

16. We therefore do not consider Recommendation 10 from our initial report to have been fully addressed. Therefore, this recommendation will be carried forward as follows.

Progress inspection recommendation 3

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

17. Recommendation 12 from the previous report stated:

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

18. During the May 2024 inspection, there was no Standard Operating Procedure (SOP) or policy in place to support the responsive management of medical emergencies for both GPs and custody staff. The action plan submitted by the HSCP noted a SOP would be in place by April 2025. However, healthcare staff and custody staff we spoke with during this inspection were clear about the processes for managing medical emergencies and we were assured that medical emergencies would be managed appropriately.

19. Transfer to Oban and Lorne hospital was facilitated for those requiring emergency care, a place of safety, or when observation levels required could not be safely managed in the custody centre. During this inspection, we saw that a respiratory arrest bag was now available in the treatment room. This will ensure that healthcare staff can respond to medical emergencies more effectively. However, we noted that some of the equipment that it contained was out of date. The GP was made aware of this, and action was taken to replace the out-of-date equipment.

Progress inspection recommendation 4

Argyll and Bute HSCP should ensure that checks on emergency equipment and medications are carried out and consistently recorded to ensure that all equipment is within date and ready for use.

20. Recommendation 13 from the previous report stated:

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

21. During the inspection in May 2024, we were told that recommendations and information relating to a patient's assessment, including medications, were verbally given to the custody staff. We were concerned that there was a risk of healthcare information being missed or recorded incorrectly when this information was then transcribed onto the NCS. It was therefore reassuring to hear that the access to Adastra had been improved. Healthcare recommendations and information could now be printed and given to custody staff, reducing the risk of information being missed or recorded incorrectly.

22. A paper system was also available to provide custody staff with written healthcare information. We were told by custody staff that the paper system was the most used method. However, we noted that this paper version contained information relating to the patient's full medical assessment not just the recommendations and information required by custody staff to keep patients safe.

Progress inspection recommendation 5

Argyll and Bute HSCP should ensure that full medical assessments are not shared with custody staff. To protect patient confidentiality, only recommendations and guidance essential for patient safety should be given to custody staff.

23. Recommendation 15 from the previous report stated:

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

24. In the May 2024 inspection, we identified that GP's had access to the appropriate tools for monitoring levels of intoxication and withdrawals and were carrying out physical observations and prescribing detoxification medication where required. However, we saw that there could be inconsistencies in the documentation regarding the use of tools to monitor withdrawal from alcohol and substances and there was no clear process to manage this for custody staff. During our progress inspection, there were improved processes in place, which included the consistent use of validated assessment and screening tools to inform the clinical decision to prescribe detoxification medicines where appropriate for people withdrawing from substances.

25. Recommendation 18 from the previous report stated:

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

26. During the May 2024 inspection, not all GPs had access to the standardised mental health risk assessments available on Adastra,[2] therefore there was an inconsistent use of standard risk assessments to record patients' risk of self-harm or suicide. During this inspection, we were assured that despite some challenges with slow connection speed to the IT systems within the custody centre, all FMEs now have access to Adastra and can complete standardised risk assessments.

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

Next steps

28. The new recommendations featured within this report have been communicated by HIS inspectors to Argyll and Bute HSCP and Police Scotland. These will subsequently be subject to future follow up and review by HIS, plans for which will be communicated to the HSCP directly.

HM Inspectorate of Constabulary in Scotland
1st Floor, St Andrew's House
Regent Road
Edinburgh EH1 3DG

Tel: 0131 244 5614

Email: hmic@gov.scot

Web: www.hmics.scot

About His Majesty's Inspectorate of Constabulary in Scotland

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

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