Healthcare Improvement Scotland

HMICS Improving Policing Across Scotland

Joint review of police custody recommendations

August 2026

HM Inspectorate of Constabulary in Scotland
Healthcare Improvement Scotland

npm national preventive mechanism

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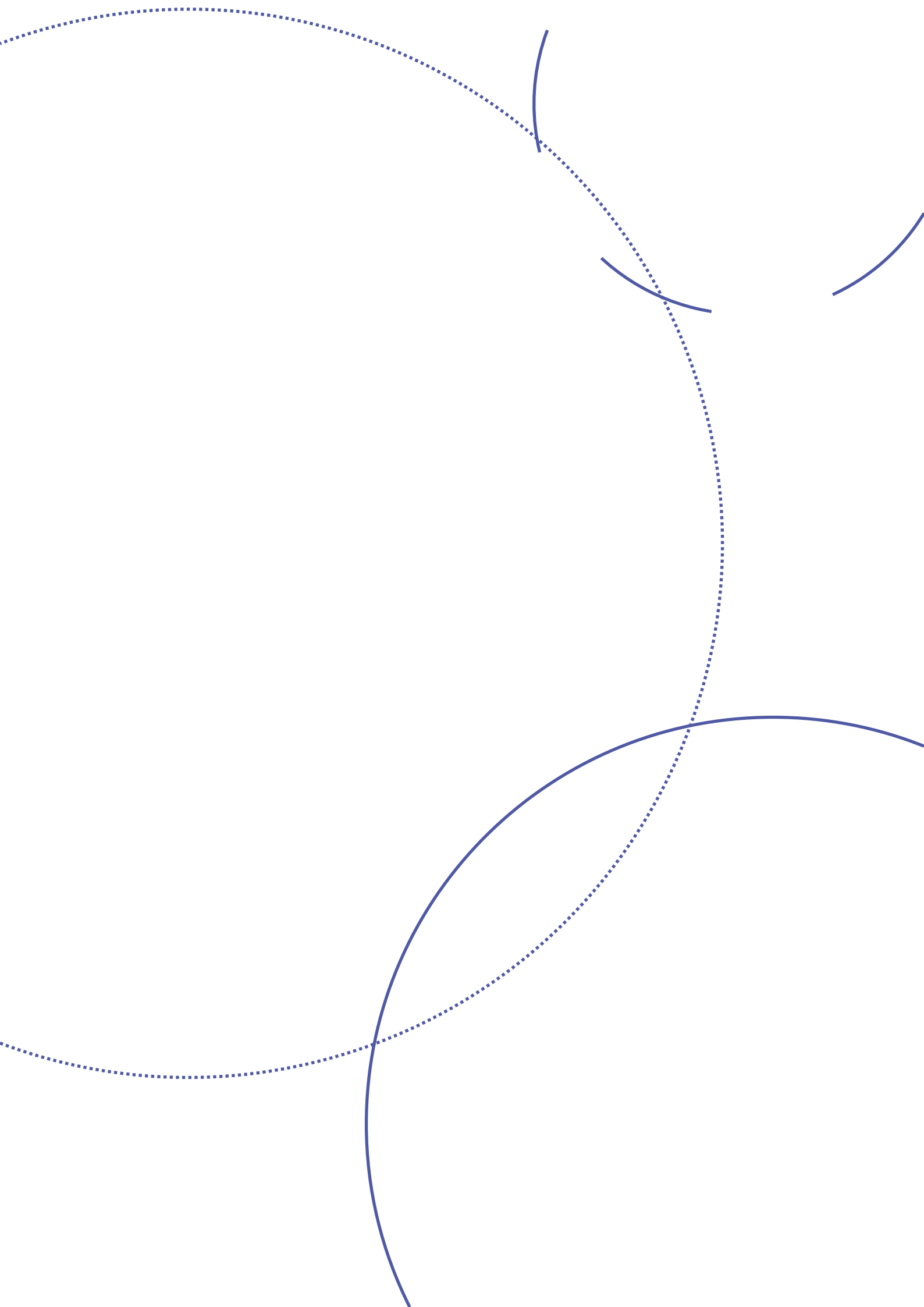


HM Inspectorate of Constabulary in Scotland

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

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

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

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

This review 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.

Context

Our review

During the course of 2022, HMICS and 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. We used learning from the review to develop a framework to inspect healthcare provision within police custody, and to devise a methodology for the joint inspection of police custody centres. The framework draws on national standards, human rights principles and expected healthcare equivalence across centres.

Thereafter, we commenced a programme of joint custody inspections and, to date, have published ten custody inspection reports and two progress reports. The findings from these can be found on our website. We have also published a revised version of our custody inspection framework, which can be found here. It outlines the quality indicators that form the basis of our inspection of custody centre operations.

The baseline review provided an important starting point for understanding healthcare delivery within police custody centres, however, the findings set out in this report are primarily drawn from our published joint inspection reports and our examination of progress made on recommendations during this review. Where relevant, reference is made to recommendations from the baseline review to demonstrate progress and to highlight areas where further improvement is required.

As outlined in our custody inspection reports, progress has been made against several recommendations; however, a number of thematic issues have persisted. This review highlights ongoing challenges relating to the custody operating model, the ageing custody estate, staffing and workforce planning, and operational practices associated with the supervision of vulnerable detainees, including children and those assessed as high risk. While we recognise that many of these pressures are exacerbated by financial constraints and the increasing vulnerability of the custody population, we consider that further action is required at pace to progress outstanding recommendations and secure sustained improvement.

In respect of healthcare provision, our inspections identified meaningful, though variable, progress across police custody centres. Areas where improvements had been identified include clinical governance, infection prevention and control, equipment and medicines management, and staff training. A number of NHS boards and Health and Social Care Partnerships (HSCP) have demonstrated effective implementation of national recommendations, with emerging examples of strengthened practice identified through inspection.

However, inspection findings also highlighted ongoing challenges. These included limitations in digital systems, delays in access to secondary mental health services, variation in the delivery of Medication Assisted Treatment (MAT), and inconsistencies in clinical governance arrangements, staff training and supervision. While improvements in staff training were identified through inspection, variation in access, consistency and supervision continued to present a challenge across services.

Overall, the joint inspection programme has contributed to measurable improvement, strengthened assurance, and enhanced national understanding of risks, good practice, and areas requiring further development across police custody. Notwithstanding this progress, the pace of change in some key areas remains limited. Continued inspection focus will be required to monitor progress; however, it is essential that Police Scotland's custody division and NHS boards maintain momentum and deliver the sustained improvement necessary to achieve consistent, safe and rights-based custody services and healthcare provision.

Craig Naylor
His Majesty's Chief Inspector of Constabulary

Eddie Docherty
Director of Quality Assurance and Regulation
Healthcare Improvement Scotland
August 2026

Figure 1 - Joint custody inspection programme coverage

Key findings

- Strategic direction and leadership

  Inspectors found clear strategic intent at senior leadership level, with the Police Scotland Custody 2030 programme providing a defined framework for future transformation. However, gaps in communication and staff awareness limited the extent to which the strategy was understood across the custody estate.

- Oversight and delivery of recommendations

  Police Scotland has strengthened governance structures to oversee inspection recommendations, including the introduction of an audit and assurance governance group and audit and assurance framework. While these arrangements are positive, inspectors found that progress has been uneven, with several recommendations and recurring thematic issues persisting.

- Leadership visibility and stability

  A lack of visibility of supervisory and senior leadership within custody centres continued to impact communication, consistency, and staff confidence. Frequent changes in senior roles and reliance on temporary leadership arrangements reduced continuity and momentum for improvement.

- Custody estate and operating model

  The current custody operating model was found to be outdated and not fully aligned to present demand, estate configuration, or staffing levels. The estate remains challenging to manage, with an ageing infrastructure and variability in capacity across locations.

- Staffing and workforce resilience

  Workforce pressures remain a significant concern, with staffing levels at times viewed as insufficient to meet demand. Inspectors found evidence of high reliance on staff movement, limited breaks, and reduced morale, indicating a lack of resilience in workforce planning.

- Training and professional development

  While initial custody training was considered adequate, inspectors found limited opportunities for ongoing development. Training provision for supervisory roles was described as insufficient, contributing to variability in practice and decision-making across custody centres.

- Use of ICT systems and digital capability

  Existing ICT systems were described as inefficient and outdated, with poor integration leading to duplication of effort and increased risk of error. Although recognised by senior leaders, progress towards implementing improved digital solutions remains at an early stage.

- Detainee care, risk assessment and custody practice

  Inspectors identified ongoing inconsistencies in the management of detainee risk, including a disconnect between risk assessments and care plans. Issues relating to observation levels, delayed cell visits and poor recording practices reflect findings from previous custody inspections.

- Children and vulnerable detainees

  While some improvement in oversight of children in custody was evident, inspectors found continued variability in practice, including instances of extended detention without clear rationale. This remains an area of risk requiring sustained focus.

- Recording, audit and assurance

  The introduction of internal audit processes is a positive development, however, findings were not consistently understood or embedded at local level. Recording practices on the National Custody System remain variable, limiting assurance on compliance and service delivery.

- Healthcare provision

  Inspectors identified meaningful progress in several areas of healthcare provision, including clinical governance, training, and infection prevention and control. However, improvement was inconsistent across health board areas, with variation in implementation and outcomes. There was a lack of clear oversight and quality assurance of healthcare in several police custody centres, which resulted in provision that was reactive rather than proactively monitored and managed.

- Healthcare access and clinical risk

  Persistent challenges were identified in access to healthcare, particularly in relation to mental health services, digital systems, and consistency in care pathways. Until access to specialist mental health assessment is more timely, equitable and consistently embedded across Scotland, mental health will remain one of the highest-risk areas for healthcare in police custody.

- Partnership working and national improvement

  Effective partnership working was evident across a range of areas, supporting progress in healthcare delivery and wider criminal justice outcomes. The joint inspection programme has contributed to strengthened national learning, increased assurance, and improved understanding of systemic risks relevant to healthcare provision.

- Pace of change and system-wide challenges

  While progress has been made, inspectors found that the pace of meaningful and sustained improvement remains constrained by structural, financial, and resource-related challenges. Continued focus and coordinated action are required to address longstanding and recurring issues.

Recommendations

Recommendation 1

Custody operating model and workforce resilience

Police Scotland should, as a matter of priority, develop and implement a revised custody operating model that is aligned to current and projected demand, and supported by a robust workforce strategy. This should include a detailed analysis of estate resilience, staffing requirements, improved resource deployment, and measures to support staff wellbeing and sustainability across the custody estate.

Recommendation 2

Governance, oversight and delivery of improvement

Police Scotland should strengthen governance, audit and assurance arrangements to ensure consistent and effective oversight and delivery of custody inspection recommendations. This should include improved evaluation of the impact of changes and mechanisms to ensure learning is embedded consistently across all custody centres.

Recommendation 3

Healthcare provision and partnership delivery

NHS boards should work collaboratively with custody services and key partners to improve the consistency, accessibility and quality of healthcare provision within police custody. This should include addressing variation in clinical governance, strengthening access to mental health services, improving digital systems and information sharing, and ensuring clearer role boundaries between clinical and non-clinical staff.

Methodology

1. This review was a targeted assessment of progress against recommendations arising from previous joint custody inspection reports, rather than a full inspection of individual custody centres.

2. We reviewed all recommendations from previously published joint custody inspection reports to assess the extent to which these had been progressed and embedded across police custody services.

3. HMICS inspectors examined custody records on the National Custody System (NCS) to assess operational practice, including compliance with risk assessment, care planning and recording requirements.

4. Onsite visits were carried out at custody centres in Dunfermline, Motherwell and Greenock to observe custody operations and assess implementation of inspection recommendations in practice.

5. We conducted interviews with custody staff, supervisors and senior officers to assess awareness of key challenges and the extent to which recommendations were being progressed.

6. HIS undertook a complementary programme of work, including a review of all joint inspection reports to identify the range and nature of healthcare recommendations.

7. HIS analysed improvement plans, evidence submissions and internal risk assessments to identify national themes and patterns in implementation.

8. A recommendations progress tracker, supported by NPM data, was used to provide a quantitative assessment of progress and identify national trends.

9. HIS also drew on findings from the National Baseline Review to assess progress against earlier recommendations and ensure continuity with initial inspection activity.

10. In addition, HIS convened focus groups with key partners, including Police Scotland and the National Police Care Network, to gather system-wide insight and triangulate findings.

11. Both HMICS and HIS used the joint custody inspection framework to identify the themes most frequently associated with recommendations, informing the focus and prioritisation of this review.

Context

12. Police custody plays a critical role within Scotland's criminal justice system, providing a controlled environment for the lawful detention and processing of individuals. Custody centres must balance operational efficiency with a strong focus on the care, welfare and rights of detainees, many of whom present with complex and acute needs.

13. HMICS has a statutory responsibility to provide independent scrutiny of policing, including custody services, to assess their state, effectiveness and efficiency. HIS, as the national improvement agency for health and social care, provides scrutiny and assurance on the quality and safety of healthcare delivered within custody. Through joint inspection activity, both organisations support continuous improvement and contribute to a consistent, rights-based approach.

14. A significant proportion of individuals entering police custody present with vulnerabilities, including mental ill health, substance use issues and physical health needs. These factors increase risk during detention and require coordinated multi-agency assessment and management.

15. Demand on police custody varies across Scotland and is influenced by geographic and operational factors. While overall capacity may be sufficient nationally, pressures arise at peak times, alongside ongoing challenges relating to workforce resilience and the condition of the custody estate.

16. Healthcare provision within police custody is delivered by NHS boards and is a core component of detainee care. The principle of equivalence requires that individuals receive healthcare comparable to that available in the community. However, inspection evidence highlights variation in delivery, including access to specialist services, digital infrastructure, and clinical governance arrangements.

17. Effective partnership working between Police Scotland, NHS boards, HSCP and wider justice partners is essential to ensuring safe custody services and positive outcomes for individuals, particularly in relation to healthcare access, diversion and continuity of care.

18. Against this backdrop, HMICS and HIS have undertaken a programme of joint custody inspections to assess custody operations and healthcare provision across Scotland. While these have identified positive practice, they have also highlighted recurring themes and systemic challenges. This review therefore considers progress within a context of ongoing operational pressures and the need for sustained custody transformation to deliver safe, consistent and rights-based services.

Leadership

Vision and strategic direction

19. Police Scotland's vision and strategy for custody is contained within the overarching 2030 vision for policing, which is structured around four strategic outcome pillars: safer communities, less crime, supported victims, and a thriving workforce.

20. Police Scotland has also introduced a Custody 2030 project. This is a strategic transformation initiative, aligned with the wider 2030 vision, which is designed to modernise the criminal justice services division (CJSD)[1] underpinned by a strategic plan for custody.

21. The strategic plan is aimed at improving service delivery by achieving significant change and improvement through estate modernisation and establishing increased workforce resilience. In addition, core project focus areas include:

- **National custody and productions model**: Establishing a 'hub and spoke' approach to estate management. This involves upgrading central custody hubs while closing older centres considered unfit for purpose, subject to government capital funding.
- **Regulatory compliance**: Improving adherence to the Criminal Justice (Scotland) Act 2016 by improving communication and audit procedures between local policing and the CJSD.
- **Digital transformation**: Implementing tools like the Digital Evidence Sharing Capability (DESC) to remove the manual transfer of evidence, speeding up investigations and freeing frontline resources.
- **Trauma-informed care**: Enhancing the training of custody staff and officers to better support individuals who present with a range of vulnerabilities including those resulting from mental health distress, and drug and alcohol problems.

1 The Criminal Justice Services Division (CJSD) oversees police custody services across Scotland and leads Police Scotland's engagement with key partners across the criminal justice system.

22. There is clear strategic intent at senior leadership level, with the Custody 2030 project setting a more dynamic direction with greater emphasis on continuous improvement during its timeline. The well-defined core aims have been developed through recognition of the issues raised in joint custody inspection reports and the internal analysis of performance that has become more structured in recent years. Senior officers spoke of there being a clear understanding of the challenges facing custody services, and they have recently established a project team to deliver on the strategic plan.

Communication of strategy

23. As with any strategic plan, it is of course essential that it is communicated effectively across relevant parts of the workforce. However, we found gaps in the dissemination of the strategy. Our conversations with custody staff demonstrated a lack of understanding of the strategic direction for custody and the steps that will be taken to achieve the change and improvement required. While there was a sound appreciation across custody staff teams we engaged with of the long-established goal of maintaining high standards of care and welfare for detainees, they were less certain about how this would be delivered in practice and what role they would play.

24. Some staff outlined what they described as ‘information overload’ whereby flurries of messages on a wide range of subjects emerging from the divisional coordination unit (which provides command support) could mean that key messaging gets drowned out and loses impact.

25. Custody sergeants appeared to have a firm understanding of their operational responsibilities, but variability in the perspectives and approaches of custody inspectors, who are a key link in the tactical and strategic leadership chain, can result in gaps in how strategic expectations and general operational direction is communicated to staff across the estate.

26. Despite this, custody staff highlighted that while they may not yet have a full appreciation of the strategic plan, they had a strong understanding of their individual roles and believed that by delivering these well they were effectively contributing to the wider strategic aims and objectives within custody.

27. The CJSD senior leadership team (SLT) have informed us that they will enhance communication on the strategic plan through an improved staff engagement and visibility framework, with an associated communications plan supported by a dedicated allocated resource. This will align with the Police Scotland 'People Plan' and the 'Your voice matters' engagement framework, which continues to serve as a conduit for staff opinion and feedback.

Oversight of recommendations

28. During this review, we sought to establish the effectiveness of Police Scotland's oversight and governance of the delivery and implementation of recommendations resulting from the joint custody inspection reports published since April 2023.

29. In addition, we examined the extent to which NHS boards that had been subject to inspection had progressed recommendations effectively. We provide further detail on the arrangements made by NHS boards to address and implement recommendations in the healthcare section of this report. This section outlines findings from activities undertaken by HIS to carry out the review. It also provides an analysis of progress and areas requiring ongoing improvement.

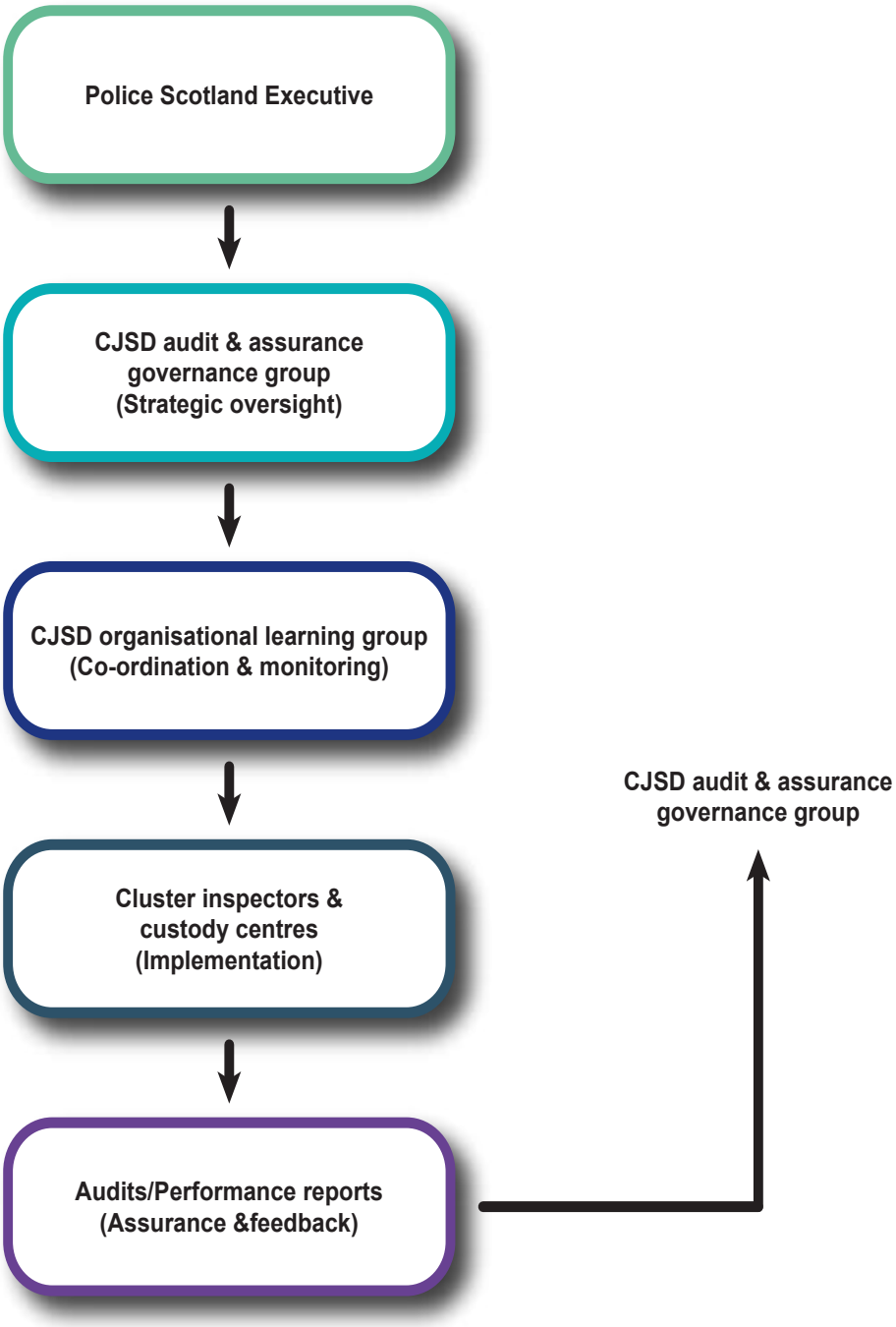
30. Police Scotland meets its responsibility to review and address custody inspection recommendations through the senior leadership structure of CJSD, with the support of internal teams including the CJSD Continuous Improvement Unit.

31. Senior leaders acknowledged that there had been a lack of momentum regarding the oversight and delivery of existing recommendations and highlighted the need for enhanced auditing and governance structures to improve accountability, secure continuous improvement, and ensure the effective delivery of recommendations.

32. In order to address this, CJSD has initiated an audit and assurance governance group, which is a monthly senior management governance meeting aimed at prioritising the delivery of HMICS recommendations as part of an action driven approach. Chaired by the CJSD chief superintendent, this group has been endorsed by the Police Scotland executive and forms the main strategic mechanism for delivering on recommendations.

33. As a result of audit and assurance group actions, CJSD has developed an audit and assurance framework intended to ensure a pro-active, welfare-centred approach to learning and continuous improvement. The task of coordinating the delivery of HMICS recommendations has been adopted by a recently formed organisational learning group. This group has commenced a schedule of regular monthly meetings with SLT attendance and aims to provide regular updates to the governance group to ensure appropriate oversight of the audit and delivery process.

Figure 2 - CJSD audit and assurance governance structure



34. In addition, weekly meetings have been introduced between the CJSD superintendent and the custody cluster inspectors that have been tasked with maintaining HMICS recommendation updates via a shared spreadsheet to drive local improvement. The cluster inspectors have welcomed this improved focus and support.

35. In practice, the audit and assurance approach aims to review around 350 custody records each month from the police NCS, to assess compliance and identify learning that could be shared across custody centres. Regular performance reports on the results from the auditing process are generated to monitor progress, identify locations that may require support, and to highlight key themes emerging from the audited records.

36. We found that highlights from this had not been fully cascaded to custody centres as many of the custody staff we spoke with were unaware of the audit and assurance approach and auditing of records. Nevertheless, it was evident that some of the findings from these internal audits had been circulated to staff via memos and briefings intended to promote improvements in service delivery.

37. For example, custody staff confirmed they had received instructions resulting from HMICS recommendations that related to the application of greater scrutiny and discretion around the strip-searching of detainees, mandatory fire evacuation drills, maintenance of appropriate stock of anti-harm clothing, and appropriate application of detainee risk levels. Our review found, however, that several of these issues have continued to present a challenge in custody centres, which highlights that ongoing work remains to achieve broad, consistent and lasting change in operational practice.

38. Many of the supervisors we spoke with welcomed the direction and clarity resulting from the recommendation oversight arrangements, however, were frustrated by a lack of consistency in the implementation of recommendations across the custody estate. They also raised the impact that staffing challenges had on achieving greater consistency. In addition, they felt that not enough was being done to reinforce and consolidate the learning that had been achieved and, more crucially, to evaluate the effectiveness of the changes that had been made as a result of recommendations.

39. When assessing the effectiveness of the oversight of recommendations, consideration must be given both to the number of outstanding recommendations and the regular recurrence of common themes when we undertake new custody inspections. These factors highlight the need for continued emphasis on governance arrangements, a strong focus on the evaluation of what is working well as a result of changes made, and on ensuring increased consistency across the estate.

Arrangements to address strategic risks

40. Police Scotland have mechanisms in place to identify and oversee strategic risks associated with the delivery of custody services, including formal risk registers and senior level oversight.

41. Other governance approaches have been established, including use of the 4risk[2] management tool, which enables the structured evaluation of identified business risks, supports strategic focus and informs the tactical and operational response. For example, custody resourcing and the custody estate are recorded as high-level risks and therefore occupy priority positions on the system.

42. However, there remains room for refinement. For example, risks relating to local policing are captured elsewhere and therefore creates the potential for strategic blind spots and reduced comprehension of the wider operational policing impacts of custody specific challenges. To address this anomaly, risks to local policing resulting from custody challenges or demands are considered by the CJSD operations superintendent who engages directly with local policing commanders through a joint operations forum.

Leadership visibility

43. The effective cascading of strategic aims and priorities beyond senior level is often hampered by limited supervisory and leadership visibility within custody settings. We have highlighted in our custody inspection reports that gaps remain, in some locations, in the regular and consistent presence of managers within custody centres. This can lead to variable staff experiences and inconsistent leadership, oversight and direction.

2 4risk is a cloud-based risk and business assurance platform offered by the business advisory firm RSM UK. It provides organisations with a real-time view of their risk registers, controls, and compliance environments.

44. The issue often centres around the visibility of cluster inspectors, who perform the critical role of first line managers for operational supervisors and second line managers for staff. Where gaps exist, it can impact on the quality of communication between the SLT and custody staff. It can also impact on service delivery as new or less experienced staff are more reliant on leadership direction.

45. SLT members agreed that the visibility of managers in custody is highly important and recognised that there were instances where this could be improved. As a result, the divisional commander is reviewing a new staffing framework, which includes a stronger emphasis on visible leadership, demonstrating that this is recognised as a key issue in need of swift resolution.

46. In an effort to improve senior leadership visibility, regular voluntary online meetings and forums under the banner 'Meet the Commander' have been introduced, and all staff are actively encouraged to participate in the sessions. Some staff viewed these positively with one CJPCSO team leader speaking highly of SLT efforts to engage, stating they felt listened to and appreciated. More generally however, levels of staff uptake were found to be varied, and inspector level visibility in the forums was described as mixed.

47. A CJSD operations superintendent oversees the operational delivery of the national custody estate, which is vast and subject to significant logistical challenges regarding transportation in some areas. That said, many staff stated that the operations superintendent had made concerted efforts to visit several locations and engage with staff.

Leadership stability

48. The above noted challenges regarding communication and visibility are further exacerbated by issues regarding leadership structure and a lack of stability in some senior roles.

49. We consider that in order to ensure the effective implementation of custody recommendations at all levels, leadership arrangements should be clear and consistent. In addition, it is important to maintain stability in leadership roles wherever possible. While we recognise that, at times, most policing divisions can experience change and instability due to routine changes of personnel linked either to promotions, secondment or retirement. However, it is evident that CJSD have experienced a significant degree of flux across several key positions in the leadership structure.

50. A regularly cited criticism among custody staff is the frequency of change among senior managers which has, over the past few years, seen four incumbents of the divisional commander role alone. Similar changes have been seen in other parts of the management structure, which staff state can create uncertainty and inconsistency in messaging and prioritisation, and has resulted in a loss of momentum for change.

51. Other factors cited relate to the regularity of leaders occupying temporary promotions, whereby their tenure could be interrupted by departure following substantive promotion. Staff suggest that this can result in 'short termism', which can impact on progressing changes resulting from recommendations and internal auditing. This is particularly relevant when considering the scale and complexity of tasks associated with the change programme currently being undertaken.

52. Some staff have stated that there is a lack of corporate memory in the division as a result of regular changes in leadership and management, which can mean that the same issues are examined every few years. Some custody inspectors new to the division, who as line managers serve as a critical conduit between leadership and delivery, appear less clear on operational priorities, and staff feel that they regularly rely on their own experience to deliver services. However, our custody inspection reports have regularly found the first line management provided by custody sergeants to be strong and often grounded in considerable experience.

53. When custody staff were asked about potential barriers to change and improvement, they identified frequent staff turnover or 'churn' within custody, including among supervisory staff, as the primary issue. This, it was said, could lead to newly developed national policies and practice being overlooked in favour of reverting to traditional and potentially outmoded practice due to staffing pressures.

Custody estate and staffing

54. Police Scotland has not yet effectively addressed the challenges of maintaining a custody estate that is consistently well resourced and fit for purpose.

55. The estate strategy is currently being reviewed to ensure it meets the levels of demand across the country, while addressing the legacy issues of an aging estate, much of which requires considerable ongoing maintenance.

56. Senior leaders recognise the need to review the operating model including the number of centres, resource levels and resource distribution. An established staff to cell ratio of 1:10 is widely quoted, although most people we met with during our review were unclear on the formal basis or origin of this figure. However, leaders are now reviewing this to determine what staffing ratio fits best for the transformation programme, giving due consideration to varying demands across the estate.

57. The division operates a number of ancillary centres that can be opened when required to flex the estate in response to demand. However, inconsistency in the use of these centres causes confusion and introduces additional challenges. There is a stated desire to move towards a hub and spoke custody model designed to better meet demand, however this brings its own challenges in terms of increased impacts on detainee and officer movement, which in turn can place a higher burden on local policing resources.

58. We learned from CJSD that statistics show they have more cell capacity than required to meet demand. Conversely, most staff report acute capacity challenges at weekends, with some describing staffing levels as unsafe at times.

59. During interviews with senior leaders, there was broad agreement that careful consideration of demand across both urban and rural locations would be required to inform the custody estate review. Variability in demand poses a significant challenge on evaluating the appropriate staffing resource to meet the care and welfare needs of detainees and deliver effective custody operations.

60. Senior leaders also highlighted the potential impact of interdependencies between custody and local policing. Local policing is reliant upon custody services, however the current custody operating model can have significant implications for local policing resource abstraction.

61. Our review has found occasions where the current operating model of temporarily closing custody centres in response to staffing pressures has resulted in longer journeys for detainees and escorting officers between the remaining centres and other locations including courts. This will of course be an additional consideration that needs to be factored into custody estate planning.

Partnerships

62. CJSD appear to have well developed and thriving relationships with relevant partners with responsibility for criminal justice services and with links to police custody. Custody managers referred to recent collaborative workshops with Scottish Government, the Scottish Prison Service, and community justice partners to explore reducing current bail and remand populations. In addition, custody leaders have engaged with the Scottish Courts and Tribunal Service and Deloitte to consider the potential for streamlining court processes and improving end-to-end systems.

63. There have been advanced discussions with multi-agency partners in preparation for the imminent transition to a new custody transport provider, which demonstrates proactive preparation for a business area that in recent years has presented significant challenge to the effective operational delivery of custody.

Progress on recommendations

64. As noted previously in this report, we have published ten joint custody inspection reports with our colleagues from HIS, as well as two progress reports. This resulted in 45 recommendations and 33 areas for improvement being made for Police Scotland and 104 recommendations for NHS boards. In addition, HIS made 11 areas for improvement for NHS boards, and outlined 32 examples of good practice where these have been identified during inspections.

65. Details on the dates and locations of these inspections can be found at appendix A. The number of recommendations made for Police Scotland regarding each custody centre, is outlined at appendix B. Recommendations for NHS boards are at appendix C.

66. When considering the data outlined in the appendices, it should be noted that for the purposes of reporting on progress, we have separated the recommendations by those made to Police Scotland and those directed to NHS boards as the lead organisation. However, we recognise that in practice the organisations have joint responsibility for some recommendations.

67. In terms of tracking recommendations, we request an action plan from Police Scotland approximately three months following publication of an inspection report. Thereafter, Police Scotland complete an evidence submission form for each recommendation, and our inspectors review these for consideration of closure. Depending on the nature of the recommendation it can take a varying degree of work and time by Police Scotland to achieve its closure.

68. We do not track areas for improvement made for Police Scotland in the same way as our recommendations as these tend to focus on local custody centre issues such as repairs or improvements in localised practice as opposed to the more thematic nature of our recommendations. That said, Police Scotland can provide updates on progress against these at any time, and we can also explore progress during future onsite inspections.

69. HIS adopts a risk based, evidence informed approach to monitoring progress against inspection recommendations. Following publication of a custody inspection report, the NHS board and HSCP are required to submit a structured action plan setting out how each recommendation will be addressed. The action plan is reviewed, alongside supporting evidence where requested, and is subject to internal risk assessment to determine the level of assurance and any remaining risk. Formal feedback is then provided to the NHS board outlining our assessment on progress and identifying where further action is required.

70. The assessment considers if sufficient progress has been made, whether work is ongoing, or whether the recommendation is no longer applicable considering changing circumstances. Where risks remain, or progress is incomplete, this is clearly articulated and followed up through subsequent inspection activity, targeted engagement, or follow-up work to ensure that scrutiny is proportionate, focused and aligned to areas of highest risk to the safety and quality of care.

71. The following sections of this report provide details of our findings from the activities undertaken during our recommendations review. It considers progress made against existing recommendations, the extent to which they have impacted on operational practice, and where more needs to be done to achieve positive outcomes.

Custody operating model

72. The current police custody operating model is based upon the pre-Police Scotland legacy custody estate and infrastructure operated by staff comprised of police officers, civilian support staff and partners. Staffing resource is not informed by a bespoke custody demand analysis but is instead broadly determined by the number of cells at a custody centre, the number of detainees ordinarily detained, and the minimum ratio of one member of staff to ten cells that was introduced for management purposes.

73. This arguably outdated ratio, commonly referred to as the operating base level (OBL), was established through a relatively arbitrary estimation of staff capacity, rather than being founded on a quantifiable examination of operational risk and delivery. Since the inception of Police Scotland in 2013 there have been a number of custody centre closures which have, in the main, been implemented to achieve greater efficiency across the national estate.

74. The operating model is widely viewed by staff as unsafe and unsustainable as staff numbers can, at times, fall below the OBL. Until recently, the model was heavily supported by staff overtime, which of course comes at a cost. A reduction in overtime, following budgetary pressures, has exacerbated the issue as the current operating model makes it difficult to deliver services without overtime.

75. Some staff members highlighted the role of the team leader in relation to staffing levels. Whilst team leaders are supervisors and are responsible for care and welfare decision making, they are counted as a working staff member. Some agree with this approach, however others suggest this enables lower than acceptable staffing levels. Staff also described how resources often seemed to be in the wrong place at the wrong time due to a lack of effective staff roster management in some areas.

76. In the more populated parts of the country, weekend cell capacity was widely described as critical, with some detainees being transferred long distances between centres. The closure of Kirkcaldy, Coatbridge and Kilmarnock custody centres to address staffing pressures can result in longer transfers and extended queues at receiving centres. While there may be sufficient cell capacity nationally, at critical times, there is limited resilience in high volume areas.

77. Our review, and previous custody inspections, have highlighted that the operating model is not suitable for the existing estate, the current level of demand, and available staff resource.

78. The SLT for custody have identified the development of a new operating model as a top priority, noting that the current model is not fit for purpose and is sustained largely through goodwill and extensive staff movement across the estate. Police Scotland has engaged a firm of third-party analysts to explore the existing operating model in consideration of the issues identified regarding the custody estate, staff resource and demand levels to produce a model capable of supporting positive change and development. The outcome of this work is not yet clear.

79. The issues have been incorporated into the CJSD custody transformation programme for ongoing attention by the project team.

People strategy and workforce planning

80. We found that Police Scotland does not have a clearly defined people strategy for custody. Workforce arrangements lack resilience, with non-voluntary deployments to other centres, high staff absence, limited wellbeing focus, and insufficient training and development contributing to poor morale.

81. Some senior officers acknowledged that regular changes in senior personnel and second line managers within the division has impacted on operational certainty and continuity for staff. Moreover, they recognise that staffing pressures, which necessitate the movement of staff to cover shortfalls or absences at other centres, has had a demoralising effect.

82. A lack of resilience in the staffing model means that unpaid breaks are rarely taken, especially at busier times. The absence of rest breaks can potentially lead to errors, increased stress and further absence.

83. An additional factor affecting morale is the number of staff on restricted duties within custody, which inevitably places increased demand on other staff. This was acknowledged by senior officers who are working to address the issue.

84. The SLT highlighted that work is in place to improve staff morale, including development of the trauma response framework, which sets out support for staff in the event of an adverse incident. It was acknowledged that this work needs to move at pace, requires staff buy in, and must be delivered sensitively.

85. A new resource deployment unit (RDU) has recently been created for the division to better manage resources. While it is at an early stage, staff feel that the impact of this is yet to be realised, though they remain hopeful that as RDU staff become more familiar with local staffing structures and demands, they will begin to see improvement.

86. A national custody coordinator role is also being proposed to better manage demand and control inflow to custody centres. This would provide options to direct officers escorting detainees to centres with available capacity, for example travelling further to a centre with no waiting time rather than attending a closer centre that is experiencing long queues.

87. We have previously made recommendations regarding staffing levels following the joint inspections in Greater Glasgow, and Argyll and West Dunbartonshire. We recognise that this is a significant issue that will take time to resolve and will feature heavily in custody transformation plans. However, more needs to be done to build resilience in the staff complement, reduce pressure points where staff are increasingly stretched, and to restore the strong relationships that the division has maintained with staff over an extended period.

Staff training

88. Effective training and the professionalisation of the custody role were widely seen as key to consolidating improvement and supporting longer-term change for CJSD. At present, basic custody training is the same for all practitioners. It is considered by staff to be adequate overall, however, many feel it lacks situational relevance and does not reflect the realities of day-to-day practice.

89. Once staff have completed the basic five-day custody course there is little further training. CJSD recently introduced refresher training, however many staff members felt that this offered little more than basic training.

90. As supervisors, sergeants and team leaders attend a first-line managers' course. This was previously a two-week college course, however it is now delivered as three half-days online. Supervisors stated that the course has become overly condensed and diluted, and while some aspects are valuable, it does not fully meet the needs of the supervisory role.

91. Custody sergeants reported that there is no specific training for the duty officer role, and they generally learn on the job from peers. This approach relies heavily on peers having a sound understanding of operational delivery procedures, and a high level of competence. It is therefore prone to inconsistency across the estate. Similarly, there is no specific training for the team leader role, which can result in variability in approach and performance. There was an acknowledgment by custody leaders that training currently falls short of what would be desired, with a pressing need for improvement, including through a more scenario-based syllabus.

92. We found broad acceptance that there is a need for additional training on the Criminal Justice (Scotland) Act 2016, to assist local policing officers to fully understand essential custody requirements. Despite previous efforts, there continues to be a mixed understanding of the implications of the legislation on custody practice.

93. It will be necessary therefore for staff training and development to feature strongly in custody transformation plans.

ICT systems

94. Many of the staff we engaged with described the NCS as straightforward and functional, however regarded it as outdated and unintuitive. Staff described the system as time consuming to navigate and disjointed, leading to unnecessary delays, which could encourage the use of shortcuts. They felt that an improved system should include more mandatory fields and pop-up boxes to prompt users to understand what content is required and where.

95. In our previous custody inspection reports we have highlighted significant gaps in the use of NCS, which has made it difficult for inspectors to assess the extent to which standard custody processes are being completed correctly. Custody staff stated that considerable time could be saved by improving the integration of the various platforms to avoid repetition, and we have made a recommendation to that effect. We have previously identified significant inefficiencies arising from poor integration between police IT systems, resulting in repeated manual data entry across multiple platforms, which increases the risk of error.

96. Other ICT related issues have also been raised by custody staff. Several years ago, CJSD issued electronic tablets to custody centres so that interactions between staff and detainees could be recorded contemporaneously. This was intended to address a previous recommendation, made following a joint custody inspection, whereby gaps and delays were identified in the recording of detainee observations within their cell.

97. The ability to record on the devices was intended to improve accuracy, efficiency and provide increased confidence in the practice. However, the tablets were underused for a range of reasons. Some staff stated that the software interface lacked useful functionality. Others found them difficult to use due to wi-fi problems in some centres. More recently, they were considered to pose a potential risk to the health and safety of staff and, as a result, all tablets were withdrawn. As far as we can ascertain, the situation remains unresolved.

98. Senior officers have recognised the limitations of existing custody ICT systems and stated that they are taking steps to explore new technological solutions. However, progress is at an early stage, with reliance on short term fixes and no fully developed digital solution yet in place to deliver meaningful improvement. Cost will undoubtedly be a factor as a result of funding challenges.

Review of NCS records

99. In order to assess progress on the aforenoted recording issues, as well as other operational practices, we undertook an analysis of custody records on NCS as part of this review.

100. We examined a proportionate sample of custody records from those recorded across all custody centres during the period between 19 and 25 January 2026. There were 1,797 records created in that period and we sampled 154, which equated to approximately 8.5%. The sample was selected to be broadly representative of the proportions of men, women and children who were held in custody at the time.

101. The review of NCS records provided valuable information on several aspects of custody centre operations, including risk assessment and observation levels within custody, and compliance with Police Scotland's Care and Welfare of Persons in Police Custody SOP.

102. We found issues that were consistent with our findings from previous joint inspections of custody, many of which are the subject of existing recommendations. However, we also found examples of improved practice.

103. Children in police custody has been recognised by the National Police Care Network as an area in which many elements of the Target Operating Model (TOM) Future State[3] required further implementation. A broader multi-agency programme of work is being led by the Children and Young People's Centre for Justice to support the implementation of the Children (Care and Justice) (Scotland) Act 2024 with a view to reducing the number of children in custody. Joint inspection activity by HMICS and HIS has repeatedly highlighted concerns regarding the detention of children. These include instances of children being held in custody for prolonged periods, for what inspectors considered to be relatively minor offences, and without sufficient management oversight or a clear rationale being recorded for custody decisions.

104. Although the overall number of children entering custody remains relatively low, inspection findings indicate that when children are detained, variability in practice presents heightened risks to their rights, safety and wellbeing. Strengthening the healthcare response, workforce capability and oversight of the care children in custody receive is essential to ensuring compliance with a rights-based approach and the delivery of trauma-informed, child-centred care.

105. We reviewed 25 records for children and young people within our sample and found that the majority, 20 of 25, had been subject to oversight by a custody review inspector. While we would expect to see all cases of children in detention being overseen by a custody inspector, this marks an improvement.

106. However, there were two instances where a child was held in custody for an extended period without a clear rationale being recorded on the system. Again, while this is a relatively small number and reflects improvement, we continue to see inconsistency in the oversight and management of children across the estate.

107. We also noted instances of adults being held in custody long after a decision was made to release, an issue raised in previous inspections. In one case, a decision was made to release an individual soon after their arrival, but the detainee was held for a further 25 hours. It is essential in such cases that a clear rationale is recorded to explain and justify the extension.

3 The Target Operating Model (TOM) Future State describes the nationally agreed vision for police custody healthcare in Scotland, setting out the improvements required to deliver consistent, equitable, person-centred and trauma-informed healthcare across all custody settings.

108. We have consistently noted a practice where detainees are assessed as high risk at the booking-in stage, but managed at a lower level, without clear mitigation of risk being applied. Of 88 records assessed as high risk, we noted that a third of these were managed at a lower level with no clear rationale recorded to explain the circumstances. There continues to be a stubborn disconnect between high-risk assessments and the risk management response.

109. In accordance with standard operating procedures, detainees must be visited at least hourly by custody staff, and for those deemed to be of higher risk, visits can be at 30 or 15 minute intervals. We found that observation checks had been recorded in 135 of 154 records from our sample. However, many of these had been recorded up to ten minutes late. We found 10 records with checks that were late by more than ten minutes, the longest delay being 35 minutes. Many detainees are vulnerable and timely visits are important to ensure their care and welfare. We recognise that this remains a challenge for custody, particularly in consideration of the aforementioned staffing challenges, however given what has been said in this report about better use of ICT systems, and improvements to the operating model, more needs to be done at pace to resolve the issue.

110. Forty-seven records indicated that a detainee had been strip searched. All but two were appropriately authorised by a custody sergeant. In ten records, the rationale to justify a strip search was very limited. One had no rationale, and in seven there was no search page. We have highlighted the necessity for improved practice in recording a suitable rationale for strip searches in previous recommendations.

111. There were three records related to ancillary centres in our sample that lacked an adequate level of remote supervisory oversight. This subject was raised in our joint inspection of custody centres in the Highland and Islands division and remains an issue for ongoing attention from the custody division.

112. We found, in the majority of cases, that the recording of handovers between supervisors was often generic and lacked specific details relevant to individual detainees. This issue has been raised in previous inspection reports as a potential risk and is subject to a current recommendation.

113. As outlined previously in this report, the quality assurance and performance function is, in part, undertaken through a monthly audit based on the dip-sampling of records. While this is a welcome introduction, it is evident that further progress will be needed to continue to embed improvements relevant to the recommendations outlined in this section of our report.

Outcomes

114. As noted, we have published ten joint custody inspection reports and two progress reports since April 2023. At the time of our review, a total of 25 recommendations for Police Scotland have been closed, and 20 remained open. This marks good progress by Police Scotland and the custody division.

115. We have outlined several areas in this report that require further action and ongoing attention from the custody division to meet the standards expected of an efficient and effective custody service.

116. Implementation of custody recommendations is progressing incrementally, with some short-term improvements being delivered, but the pace of more substantial and sustained change remains constrained by structural, financial and resource related limitations, as well as the absence of an alternative operating model. Improvements relating to significant factors such as the custody estate, ICT development, and a revised staff training programme are recognised as being a longer-term goal.

117. An organisational learning tracker is maintained by the division, capturing recommendations within a central spreadsheet and enabling monitoring of progress, including following formal closure. Procedural reviews are also undertaken following instances of death, injury, or adverse incidents to identify and address poor practice, determine whether these reflect wider systemic issues, and capture and disseminate organisational learning.

118. Performance related information is shared through a range of channels, however, there is little evidence to illustrate whether performance reporting is timely, accessible, consistently understood, and tailored to the needs of different stakeholder groups.

119. Custody staff and managers spoke of considerable engagement with partners across a range of workstreams, including bail and remand, warrants, custody transport, and arrest referrals. This demonstrates sound collaboration and a proactive approach to improving end to end processes and outcomes for individuals. It also reinforces that criminal justice outcomes are often dependent on multi agency approaches, not solely on the role of policing.

120. There is limited evidence that the custody division systematically analyses or reports on the experiences and perceptions of service users and staff, and therefore more could be done to reflect the perspectives of those most directly involved.

121. The refreshed vision and strategic plan for custody transformation, supported by new governance structures, a dedicated project team, and an enhanced audit framework, has the potential to make the changes needed to progress recommendations and drive improvements in custody services.

Healthcare

Introduction

122. This section of our report summarises national progress made in the delivery of healthcare within police custody centres since the commencement of our joint inspection of police custody centres. It reflects:

- work undertaken by HIS and HMICS through the inspection programme
- common themes and issues identified across multiple sites
- examples of good practice and strengthened processes
- areas where improvements have been made, and
- areas where further action is required at local and national level.

123. The purpose is to:

- provide a clear national overview of progress
- assess the extent to which healthcare recommendations have been addressed
- support shared learning and national consistency, and
- inform future joint inspection and improvement activity.

124. We have utilised our Framework to Inspect Healthcare Provision within Police Custody Centres to establish a consistent national methodology for evaluating quality, safety and effectiveness. The framework draws on national standards, human rights principles and expected healthcare equivalence.

125. This has been used throughout our joint custody inspection programme, and in undertaking this evaluative review of recommendations.

126. As noted previously in this report, we have undertaken joint custody inspections across several police divisions and NHS board areas. Details of the areas we have visited are outlined in appendices as well as information on the number of recommendations and areas for improvement made.

National findings

127. Overall, inspection activity demonstrated meaningful progress in the governance, quality and safety of healthcare provision within police custody. However, progress has been variable across Scotland, with significant variation remaining in governance maturity, access to specialist services, workforce resilience, and digital infrastructure. These areas continue to be the main barriers to achieving consistently safe, effective and equitable healthcare for people detained in police custody.

128. Clinical governance arrangements encompass the systems, processes and accountability structures through which NHS boards and HSCPs assure themselves that healthcare delivered within police custody is safe, effective, person centred and subject to continuous improvement. Clinical governance remains one of the most variable and influential elements of healthcare delivery within police custody. Our custody inspections consistently highlighted weaknesses in the structures, oversight mechanisms and reporting arrangements that underpin safe and effective care. Across Scotland, HIS and HMICS found considerable variation in how governance was organised, how risks were identified and escalated, and how NHS boards assured themselves that the care delivered in police custody was safe, consistent and aligned with national expectations.

Progress and good practice

129. Across Scotland, NHS boards have taken steps to strengthen clinical governance arrangements in response to inspection findings. Many NHS boards have enhanced governance documentation, reporting processes and risk management systems, with evidence of improved quality assurance mechanisms, more structured action planning and better internal communication.

130. Inspections identified positive examples where NHS boards had established dedicated governance groups which focused on police custody healthcare. These groups brought together operational leads, senior managers and clinicians to strengthen oversight and improve accountability. They provide a platform for reviewing clinical risks, monitoring action plans and strengthening links to NHS board level governance committees.

131. Some NHS boards demonstrated improvements in clinical audit cycles. Where structured audit programmes had been implemented, regular audits of record keeping, infection prevention and control, medicines management and clinical documentation supported more proactive oversight and helped promote greater consistency in the delivery of care.

132. Progress was also evident in staff training and development, particularly where national resources or network led approaches had been introduced. National partners, including the National Police Care Network, provided targeted training that strengthened governance capability. The rollout of training on the Istanbul Protocol improved staff understanding of the assessment and documentation of injuries and supported more effective embedding of human-rights principles within clinical governance practice.

133. The implementation of Public Services Delivery, Scotland's National Police Care Network TOM, is expected to provide a more consistent and structured approach to the delivery of healthcare in police custody across Scotland. The TOM sets out clear expectations for governance, workforce capability, clinical oversight and service delivery, supporting improved professional development, greater standardisation of training and enhanced access to clinical leadership and peer support across services.

Key issues and remaining risks

134. Workforce capacity and capability remain closely linked to the effectiveness of clinical governance arrangements. Ongoing vacancies, staff turnover and variability in staffing models, including access to registered mental health nurse (RMN) expertise, continue to impact service resilience and limit NHS boards' ability to provide sustained assurance over the safety and quality of care in police custody. Despite areas of progress, inspections continue to identify significant and persistent weaknesses in clinical governance arrangements across police custody healthcare services.

135. Marked variation remains in how governance structures are organised, how risks are identified and escalated and how NHS boards provide assurance that care is delivered safely and in line with national expectations. A recurring issue was a lack of clarity around governance roles, responsibilities and escalation pathways. While some services operated within clearly defined frameworks, others lacked clear ownership of oversight and quality assurance. In several police custody centres, this resulted in healthcare provision that was reactive rather than proactively monitored or strategically managed. These challenges were compounded in some areas by the absence of systematic performance reporting or formal mechanisms for reviewing clinical risks.

136. Inconsistent or poorly established audit processes remained a common finding. In many police custody centres, routine clinical audit either did not take place or lacked the structure required to generate meaningful assurance. These weaknesses limited NHS boards' ability to obtain assurance regarding the quality, safety and consistency of healthcare provided within police custody settings.

137. Inspections also identified ongoing weaknesses in incident reporting, adverse event review, learning systems and complaints handling. In some areas, clinical incidents were not reliably raised, recorded or reviewed, reducing opportunities for learning and potentially allowing recurring risks to remain unaddressed. Information for detainees on how to make complaints was often not clearly visible or easily accessible, and complaint handling processes were not always embedded within strong governance arrangements.

138. Workforce support also remained a significant area of risk within governance arrangements. Inspectors observed gaps in structured induction and clinical supervision for healthcare staff in several police custody centres. In some NHS boards, clinicians commenced work in police custody settings without a formal induction or orientation to the specific risks of the custodial environment. Clinical supervision arrangements were inconsistent at a national level, with many healthcare professionals lacking regular, structured opportunities for reflective practice, peer review and professional support. These gaps increased the risk of practice variation and inconsistency in clinical decision making.

139. Although progress has been made, the level of improvement remains uneven, reflecting variation in local infrastructure, workforce capacity and governance maturity. Until clinical supervision, induction processes, workforce sustainability and escalation pathways are consistently embedded, and governance structures are fully effective across all services, NHS boards may continue to face challenges in providing assurance that care in police custody is safe, person centred and delivered in line with national expectations.

Access to healthcare screening and role boundaries

140. Access to healthcare in police custody relies on police custody staff undertaking the initial screening of individuals on arrival. This first stage of assessment determines whether clinical input is required, how urgently a person should be seen and what risks require management until healthcare staff can attend. Inspections have consistently found that this essential triage activity is undertaken by police custody staff who are not clinically trained yet are required to make decisions involving complex physical and mental health presentations. While this process is necessary within current service models, it continues to contribute to variability in access to care and places significant responsibility on non-clinical staff.

Progress and good practice

141. Inspection evidence indicates some improvement in awareness, escalation pathways and staff confidence in identifying health-related risks within police custody. In some police custody centres, clearer escalation pathways were in place, supporting police custody staff to recognise signs of deterioration more confidently and to seek healthcare input at an earlier stage. A series of webinars delivered through the National Police Care Network, including sessions focused on risk identification, has supported improvements in staff knowledge and confidence when responding to health concerns.

142. In a number of areas, effective working relationships between police custody staff and healthcare teams supported more responsive communication. Where these arrangements operated well, inspectors observed quicker identification of high-risk presentations and improved continuity of care. In addition, where NHS boards had invested in clearer guidance for police custody staff, there was improved understanding of role boundaries and responsibilities. Police custody staff in these areas reported increased confidence and greater consistency in decision making when managing detainees with health needs.

Key issues and remaining risks

143. Despite these areas of improvement, access to healthcare in police custody remains variable across Scotland. Inspections consistently highlighted significant differences in how detainees are screened, including variation in documentation, interpretation of health concerns and thresholds for escalation to healthcare services.

144. A recurring national issue remains the absence of clear, nationally agreed expectations around waiting times for healthcare assessment in police custody. While inspectors recognise that a rigid target-based approach would be inappropriate, given that urgency must be informed by clinical judgement, the lack of national clarity continues to contribute to delays and inconsistency in access to care. This was particularly evident for individuals experiencing mental health crises, substance withdrawal or acute physical health needs.

145. Variation in access to healthcare remains a systemic issue. As identified in the aforementioned national baseline review and confirmed through subsequent inspection activity, progress has been uneven and continues to rely heavily on local service design, staffing levels and informal relationships between police custody and healthcare staff, rather than being underpinned by consistently applied national standards.

146. In police custody centres without 24 hour onsite healthcare provision, police custody staff continue to manage individuals with significant health needs for prolonged periods. Inspection evidence indicates that, in some cases, custody staff were asked to undertake activities that approached or crossed into clinical tasks. This reflects longstanding role boundary pressures identified in the baseline review and places staff in unsupported positions, while increasing risk for individuals whose needs require timely clinical assessment and monitoring.

147. Across all police custody settings, non clinical staff remain central to the identification, monitoring and escalation of health needs. While this reliance is partially mitigated in some areas through on site clinical provision or access to telephone advice, it continues to place significant weight on non clinical judgement at critical decision points. Where healthcare is provided through off site or on call models, reliance on non clinical staff may be prolonged, and clarity around role boundaries becomes increasingly dependent on the strength of local arrangements rather than consistent national assurance.

148. Inspections also identified limited consistency in how waiting times for healthcare assessment were recorded, reviewed and escalated. This reduces visibility of unmet need within police custody environments and limits NHS boards' ability to monitor whether delays remain proportionate to clinical risk. As a result, current arrangements do not consistently provide sufficient assurance that risks associated with delayed or deferred clinical assessment are being systematically identified, monitored and mitigated.

Clinical environment and infection prevention and control (IPC)

149. The clinical environment within police custody settings plays a key role in supporting safe, effective and dignified healthcare. Our joint custody inspections identified some progress in local infection prevention and control arrangements, alongside continuing challenges linked to infrastructure, equipment management and oversight.

Progress and good practice

150. Inspections identified examples of positive practice where NHS boards had taken action to strengthen IPC arrangements within police custody settings. In some centres, dedicated IPC leads had been introduced, supporting clearer accountability and more consistent application of standards. Improved stock management systems and structured checklists were also in place in several locations, helping staff to maintain supplies and complete routine equipment checks more reliably.

151. Where governance arrangements were clear, and staff engagement was strong, inspections found improved compliance with IPC standards. In these settings, environmental risks were better identified and mitigated through regular monitoring, clearer documentation and more structured oversight.

152. Several NHS boards had also introduced new or revised cleaning schedules, strengthened equipment-checking processes and improved documentation of IPC audits. These actions were supported by local action plans and follow-up activity, demonstrating responsiveness to inspection recommendations and contributing to improved assurance in affected centres.

Key issues and remaining risks

153. Despite these improvements, inspections continued to identify widespread and systemic gaps in IPC compliance. Common issues included incorrectly labelled or overfilled sharps containers, inconsistent segregation of clinical waste and insufficient or poorly managed supplies of personal protective equipment. These weaknesses were often linked to unclear local arrangements for replenishment, auditing and routine monitoring of essential IPC resources.

154. The management of emergency equipment remained a significant area of concern. In several police custody centres, emergency bags were found to be incomplete, out of date or lacking evidence of regular checks. These findings presented a clear clinical risk and highlighted ongoing weaknesses in local governance and assurance processes.

155. Environmental constraints also continued to limit the quality and safety of care. Many police custody centres operated within ageing estates, with clinical rooms that were too small, poorly ventilated or otherwise unsuitable for modern healthcare delivery. Inadequate space created practical challenges for staff and, in some cases, compromised privacy and dignity during clinical assessments.

156. While some aspects of IPC practice have improved, inspections found that environmental risks remain largely unresolved, particularly where improvement requires wider organisational planning or capital investment. Inconsistent oversight, especially in remote or rural police custody centres, continues to pose risks to patient safety. Until environmental standards and IPC arrangements are more consistently embedded and monitored, the clinical environment will remain a limiting factor in the delivery of safe and effective healthcare in police custody.

Digital and information systems

157. Digital infrastructure continues to represent one of the most persistent and system-wide challenges affecting healthcare delivery in police custody. The national baseline review identified significant limitations in digital systems as a critical barrier to the delivery of safe and effective care, particularly in relation to clinical documentation, information sharing and continuity of care. Findings from inspections confirm that these challenges remain evident in practice, indicating that the issues identified through the review have not yet been fully resolved.

Progress and good practice

158. In a small number of police custody centres, healthcare staff demonstrated consistent and effective use of the digital systems available to them. Where clearer local processes were in place, records were completed more reliably, and continuity of clinical information was better maintained. These examples illustrated the potential benefits of digital systems when supported by clear expectations and staff engagement.

159. Some services also made limited use of available data to support service planning or inform staffing and resource decisions. Although constrained by system limitations, these approaches highlighted how improved digital functionality could strengthen governance, oversight and quality assurance if systems were fit for purpose.

160. At a national level, the National Police Care Network escalated concerns about the primary clinical recording system to the Scottish Government and engaged with the system supplier to clarify upgrade plans and address performance issues. This represented important system-level recognition of the risks and the need for coordinated action.

Key issues and remaining risks

161. Despite these developments, inspections confirmed that digital infrastructure remains a significant and unresolved risk. A consistent finding was the lack of essential functionality within the primary healthcare recording system used in police custody settings. Staff reported that the system was unreliable, slow, and unable to support meaningful data capture, extraction or reporting. This severely limited NHS boards' ability to monitor performance, audit care or gain assurance around quality and safety.

162. The absence of interoperability between NHS and police custody systems continued to present a major barrier to safe and efficient care. As electronic transfer of information is not possible, critical healthcare information must be shared verbally, in writing or via email. These manual processes increase the risk of errors, omissions and inconsistent record-keeping and undermine continuity of care, particularly at key transition points.

163. Digital capability remains one of the highest-risk areas with the least local control over improvement. System limitations continue to affect the accuracy and accessibility of clinical information, delay decision-making and increase reliance on staff workarounds. While national escalation has taken place, the pace of improvement remains slow, and inspection findings indicate that digital constraints continue to impede the delivery of safe, effective and integrated healthcare in police custody.

Mental health care

164. Mental health continues to represent one of the most significant and complex areas of need within police custody. Inspection activity confirmed ongoing efforts to improve pathways and collaboration in some areas, however, access to timely, specialist mental health assessment remains inconsistent and subject to significant national variation.

Progress and good practice

165. Inspections identified examples of improving practice where care pathways were clearly defined and supported by effective joint working arrangements. In these areas, detainees experienced more timely access to specialist mental health advice, increased use of validated assessment tools and improved coordination between police custody healthcare teams and community mental health services.

166. Some NHS boards responded directly to inspection findings by clarifying escalation routes and formalising referral processes to secondary mental health services. These actions contributed to reduced reliance on police custody as a place of safety and improved clarity for staff managing individuals in mental distress.

167. Where governance arrangements supported collaboration across agencies, inspectors observed stronger decision making and improved continuity of care, particularly during transitions between police custody, health services and community-based support.

Key issues and remaining risks

168. Despite these improvements, inspections consistently found delays in access to secondary mental health services. Detainees experiencing mental distress often waited extended periods for specialist assessment, and in some cases were subject to multiple assessments before accessing appropriate care. These delays continued to place pressure on police custody environments that are not designed to manage prolonged mental health crises.

169. Challenges were particularly pronounced in rural and remote areas, where geography, travel time and workforce shortages further limited timely access to specialist mental health provision. In these settings, police custody staff and healthcare teams were often required to manage complex presentations for extended periods with limited support.

170. Variation in local care pathways and governance arrangements meant that the quality and timeliness of mental health care in police custody depended heavily on local structures and relationships. Limited availability of RMNs remained a significant factor, with registered general nurses frequently undertaking initial mental health assessments in the absence of specialist support.

171. Although inspection activity has driven some improvements, systemic delays and inconsistencies in mental health pathways persist nationally. Workforce constraints, particularly limited RMN capacity, continue to affect both the quality and consistency of care. Until access to specialist mental health assessment is more timely, equitable and consistently embedded across Scotland, mental health will remain one of the highest-risk areas within police custody healthcare.

Substance use

172. Substance use represents a significant and persistent area of health need within police custody, with many detainees arriving intoxicated, in withdrawal, or at risk of harm. Inspection activity identified examples of improving practice and collaboration, alongside continuing variation and gaps in access to consistent, evidence-based care.

Progress and good practice

173. Inspections identified examples of good practice in the management of substance use and withdrawal. Some police custody centres demonstrated more robust approaches to safe withdrawal management, supported by improvements in prescribing processes and clearer clinical oversight.

174. Several NHS boards had introduced or updated standard operating procedures for the delivery of MAT, clarifying expectations around prescribing, continuity of care and links with community substance use services. These changes supported safer transitions between police custody, court and community settings.

175. Improved engagement between police custody healthcare teams and community substance use services was evident in some areas. This closer collaboration supported more reliable continuity of treatment on release and improved planning for individuals at high risk of relapse or overdose.

176. Inspection evidence also showed that some NHS boards had strengthened substance use screening processes, prescribing decisions and clinical documentation. In response to identified gaps, local working groups had been established to review practice and align service delivery more closely with national MAT standards.

Key issues and remaining risks

177. Despite these improvements, inspections continued to identify significant national variation in the delivery of MAT. In many police custody centres, detainees did not consistently receive Opioid Substitution Therapy (OST) prior to court attendance or immediately following liberation. This disruption to treatment can increase the risk of relapse, overdose and disengagement from community services.

178. Screening processes for substance use remained inconsistent, and validated withdrawal assessment tools were not used reliably across police custody settings. These gaps limited the ability of staff to assess risk accurately and provide timely, appropriate clinical interventions.

179. Access to harm reduction interventions also remained variable. In particular, availability of Naloxone and consistent arrangements for overdose prevention education differed across NHS boards and police custody centres, reducing assurance that risks associated with release from police custody were being effectively mitigated.

180. Overall, while inspection activity has driven some strengthening of local practice, lack of national consistency continues to affect the quality and equity of substance use care in police custody. Until MAT delivery, harm reduction and screening arrangements are more consistently embedded across Scotland, substance use will remain a significant area of risk for detainees and health services alike.

Medicines management and continuity of care

181. Medicines management is a critical component of safe and effective healthcare in police custody, encompassing prescribing, storage, administration and continuity of medication during transitions into, through and out of custody. Inspection activity identified examples of strengthening governance and assurance, alongside persistent risks linked to variation in practice and system constraints.

Progress and good practice

182. Inspections identified notable improvements where NHS boards had introduced pharmacist support to police custody healthcare services. In these settings, medicines governance was significantly strengthened, with clearer standard operating procedures, improved stock control arrangements and more robust audit and assurance processes.

183. Some NHS boards demonstrated improved management of controlled drugs, including clearer application processes, safer storage arrangements and stronger clinical documentation. These developments supported greater compliance with governance standards and reduced risks associated with medicines handling.

184. Follow-up engagement confirmed that several services had enhanced local oversight of medicines management, including strengthened audit activity and improved monitoring of stock and expiry dates. Where these processes were embedded, inspectors observed improved consistency and confidence among staff involved in medicines administration.

Key issues and remaining risks

185. Despite these improvements, inspections continued to identify weak or inconsistent governance arrangements around medicines management in several police custody centres. In some settings, staff involved in medicines administration did not consistently receive appropriate training, increasing the risk of medication errors and variation in practice.

186. The lack of interoperable digital systems remained a significant and recurring risk. Medication information was frequently transferred manually between healthcare and police custody staff, increasing the potential for inaccuracies, omissions and incomplete medicines records. These risks were particularly evident at key transition points, including court attendance and liberation.

187. Continuity of medication remained inconsistent across police custody settings. Inspectors found variation in whether individuals received prescribed medicines at appropriate times, and in the arrangements to ensure continuity of treatment on release or transfer. Access to Nicotine Replacement Therapy (NRT) also remained variable, with some detainees reporting a lack of awareness that it was available during custody.

188. Overall, while inspection activity has driven improvements in medicines governance and oversight in some areas, national variation persists. Manual processes for sharing medicines information continue to present a high level of risk, and continuity of care at transition points remains insufficiently assured. Until medicines management arrangements are more consistently standardised and supported by interoperable systems, this area will continue to present a significant clinical risk within police custody healthcare.

189. Inspection findings indicate that referral and diversion arrangements for people experiencing mental health problems, substance use and physical health needs are in place across police custody settings though they are utilised to varying degrees.

190. While police custody staff play a key role in identifying vulnerability and initiating referral and diversion pathways, the effectiveness of these arrangements depends significantly on the availability, responsiveness and integration of healthcare services. The availability and impact of referral and diversion arrangements vary considerably across Scotland, with access to appropriate onward healthcare and support largely determined by local systems and inter-agency working rather than consistently delivered national arrangements.

National progress on recommendations

191. Since the inspection programme began, we have made 104 recommendations and identified 11 areas for improvement relating to healthcare across all joint police custody inspections. The number of recommendations made for healthcare, categorised by our inspection framework themes, is outlined in appendix D. Our recommendations reflect the breadth and complexity of healthcare delivery in police custody and span a wide range of domains including governance, clinical pathways, medicines management, IPC, digital systems, environmental safety, and workforce development.

192. Analysis of NHS board action plans, follow-up evidence submissions, meetings with service leads, and internal risk assessments, showed that all recommendations had been actively progressed, with none left unaddressed. However, the degree of progress varied nationally.

- A substantial number of recommendations have been fully implemented, often following significant system or process redesign, the introduction of new governance structures, or strengthened clinical oversight.
- Many recommendations were partially implemented, where meaningful work had begun, but full embedding required additional time, sustained workforce stability, or clearer system-wide processes.
- A smaller number of recommendations were inherently dependent on national infrastructure, system design and multi-agency agreement, meaning that local NHS boards cannot implement them in isolation. Inspection evidence demonstrated that further progress in areas such as digital interoperability and the establishment of consistent national mental health pathways will remain limited without coordinated national leadership and system-wide action.

193. This distribution of progress reflected a key national theme identified through inspection activity: while positive local change was increasingly evident and achievable, structural barriers, particularly digital limitations, pathway inconsistency, and workforce pressures, continued to slow or constrain the pace and scale of improvement.

Impact of the inspection programme

194. The joint inspection programme has had a clear and positive impact on the quality and safety of healthcare within Scotland's police custody centres. Evidence from action plans, follow-up meetings and progress inspections, demonstrated that inspections had strengthened governance arrangements, clarified accountability and improved the identification and management of risk. NHS boards introduced more structured IPC processes, strengthened equipment and medicines governance, and improved the quality and consistency of clinical documentation, contributing to safer and more reliable practice.

195. Inspections also prompted NHS boards to redesign key care pathways, particularly in relation to mental health, substance use and medicines management. In many areas, clearer escalation routes were established, withdrawal management procedures were strengthened, and standard operating procedures were aligned more closely with national expectations, including MAT standards. These improvements have contributed to more reliable access to care and a reduction in unnecessary delays.

196. A further notable outcome of the joint inspection programme is the strengthening of shared learning across Scotland. NHS boards are now adopting each other's tools, audit templates and governance processes, supporting the spread of effective practice and reducing unwarranted variation. As a result, the programme contributed to the development of a stronger national learning culture and improved alignment of practice and standards of care across different regions.

197. The inspection programme has contributed to a shift towards more systematic quality improvement in many areas, although progress remains variable across Scotland.

Summary and next steps

198. Inspection evidence provides assurance that NHS boards have actively engaged with and progressed recommendations arising from custody inspections. This has resulted in measurable improvements in governance, infection prevention and control, medicines management, workforce development and local care pathways. However, significant variation remains across Scotland. The most persistent risks continue to relate to the maturity of clinical governance arrangements, timely access to mental health services, workforce sustainability, digital infrastructure and the consistent implementation of MAT standards. Addressing these challenges will require continued local improvement alongside coordinated national leadership and system wide action.

199. While progress has been made across governance, clinical practice and operational processes, national consistency in the delivery of police custody healthcare remained constrained by several long-standing structural barriers. To build on the improvements achieved to date, further coordinated action will be required at national, NHS board, HSCP, and broader system-wide levels.

200. A number of key challenges cannot be resolved locally and are dependent on wider national infrastructure and agreement. Digital systems remained one of the most significant barriers, with existing platforms unable to support reliable information-sharing and effective interoperability between NHS services and police custody systems. Without national investment and digital modernisation, clinical risk and variation in access to care will persist. Similarly, coordinated national action is required to establish clear mental health assessment pathways, including agreed response expectations, to address the delays and inconsistency in access to specialist support identified across inspection activity.

201. Full implementation of Scottish Government MAT standards will require coordinated national and local planning, sufficient and sustained workforce capacity and closer alignment with community prescribing practice. More broadly, workforce sustainability remains a critical issue. The long-term delivery of safe and effective healthcare in police custody is dependent on strengthened staffing models, consistent clinical cover and robust professional support structures including supervision and training.

202. There is also a need to progress a revised Memorandum of Understanding (MoU) between NHS boards, HSCPs and Police Scotland. Existing arrangements did not sufficiently define roles and responsibilities, operational expectations or escalation routes for healthcare delivery in custody settings. A refreshed, shared MoU would help clarify accountability, strengthen governance and support more consistent effective partnership working across Scotland.

203. Addressing these system-level priorities will require sustained and collaborative effort from NHS boards, HSCPs, Police Scotland, Public Services Delivery Scotland, and the Scottish Government. Taken together, these actions represented the next steps needed to deliver equitable, safe and rights-based healthcare for all individuals held in police custody.

Inspection programme priorities

Targeted inspection

204. Inspection activity has proven highly effective at identifying risk, providing assurance and driving improvement across police custody services and healthcare provision. HMICS and HIS will continue to adopt an intelligence-led and risk-based approach to future inspection activity, informed by progress against recommendations, emerging risks, and persistent themes identified through previous inspections and review activity. Future inspection planning will focus on those custody centres, services and thematic areas where inspection evidence indicates the greatest potential risk and where recurring issues continue to be identified. Primary police custody centres not yet inspected will also form part of future inspection programming.

Focus on governance, mental health, and medicines management

205. These areas generated the highest number of recommendations and represented the most persistent risks at a national level. The inspection programme should therefore continue to apply thematic scrutiny of these domains, deepening national learning and supporting NHS boards to address the underlying structural and system-wide challenges identified.

Strengthen national thematic reporting to support learning

206. The inspection programme should continue to produce national thematic reports and progress updates to share learning, highlight recurring issues, and showcase examples of good practice. This will help accelerate improvement, promote greater national consistency, and maintain system-wide visibility of risks, progress and emerging priorities across police custody services.

Appendix A: Inspection timeline

Inspection	Police custody centre(s)	Inspection date	Publication date	Inspection type
Lanarkshire	Motherwell and Coatbridge	November 2022	April 2023	Full inspection
Tayside	Dundee	March 2023	July 2023	Full inspection
Dumfries and Galloway	Stranraer and Dumfries	June 2023	November 2023	Full inspection
Fife	Dunfermline and Kirkcaldy	October 2023	March 2024	Full inspection
Dumfries and Galloway	Stranraer and Dumfries	November 2023	April 2024	Progress inspection
Ayrshire	Saltcoats and Kilmarnock	February 2024	May 2024	Full inspection
Argyll and West Dunbartonshire	Clydebank and Oban	May 2024	October 2024	Full inspection
Greater Glasgow	London Road, Cathcart and Govan	September 2024	March 2025	Full inspection
Forth Valley	Falkirk	February 2025	July 2025	Full inspection
Argyll and West Dunbartonshire	Oban	March 2025	July 2025	Progress inspection
Highland and Islands **Highland** **Western Isles** **Shetland** **Orkney**	 Inverness, Wick and Fort William Stornoway Lerwick Kirkwall	June 2025	November 2025	Full inspection
Edinburgh	St Leonards	September 2025	May 2026	Full inspection

Total	**Full inspections**	**10**
	Progress inspections	**2**

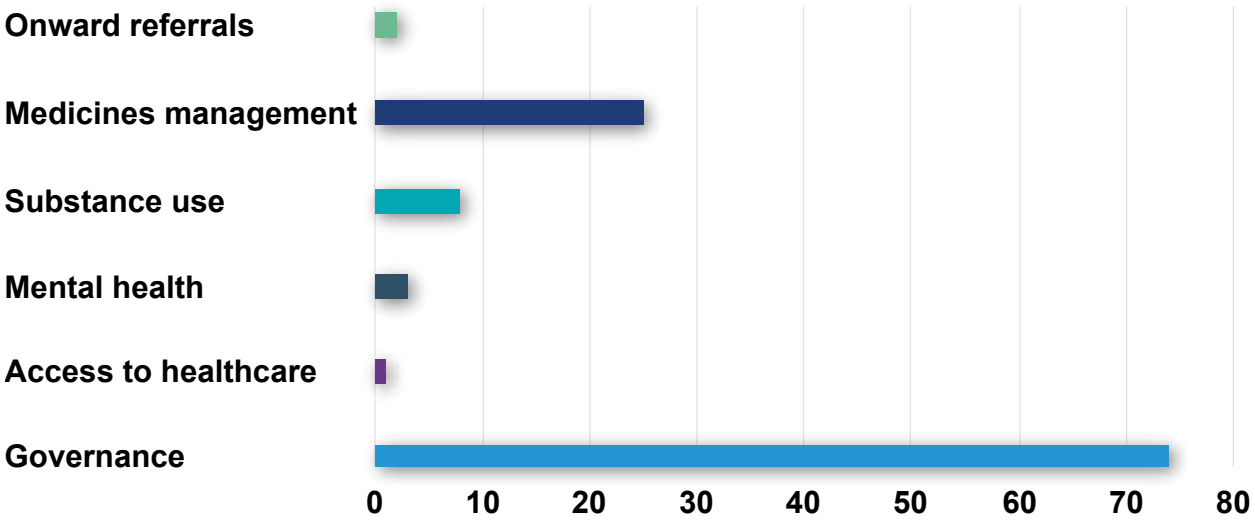
Appendix B: Police Scotland recommendations

Inspection	Police custody centre(s)	Recommendations	Status	
Lanarkshire	Motherwell and Coatbridge	8	7	**Closed**
			1	**Open**
Tayside	Dundee	4	4	**Closed**
Dumfries and Galloway	Stranraer and Dumfries	4	4	**Closed**
Fife	Dunfermline and Kirkcaldy	10	5	**Closed**
			5	**Open**
Dumfries and Galloway	Stranraer and Dumfries	0	0	
Ayrshire	Saltcoats and Kilmarnock	2	2	**Open**
Argyll and West Dunbartonshire	Clydebank and Oban	4	3	**Closed**
			1	**Open**
Greater Glasgow	London Road, Cathcart and Govan	4	2	**Closed**
			2	**Open**
Forth Valley	Falkirk	0	0	
Argyll and West Dunbartonshire	Oban	0	0	
Highland and Islands	Inverness, Wick and Fort William Stornoway Lerwick Kirkwall	4	4	**Open**
Edinburgh	St Leonards	5	5	**Open**
Total	**45**		**25**	**Closed**
			20	**Open**

Appendix C: NHS recommendations

Inspection	Recommendations	Areas for improvement	Good practice
Lanarkshire	7	5	-
Tayside	4	2	1
Dumfries and Galloway	10	2	1
Fife	5	1	2
Dumfries and Galloway (Progress inspection)	2	-	
Ayrshire	6	1	3
Argyll and West Dunbartonshire			
Argyll and Bute HSCP (Oban)	14	-	1
Glasgow City HSCP (Clydebank)	-	-	3
Greater Glasgow	2	-	3
Forth Valley	6	-	5
Argyll and West Dunbartonshire (Oban - Progress inspection)	5	-	-
Highland and Islands			
NHS Highland	7	-	4
NHS Western Isles	9	-	4
NHS Shetland	11	-	1
NHS Orkney	9	-	-
Edinburgh	7	-	4
Total	**104**	**11**	**32**

Appendix D: Recommendations by inspection framework themes



Improving Policing Across Scotland

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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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