



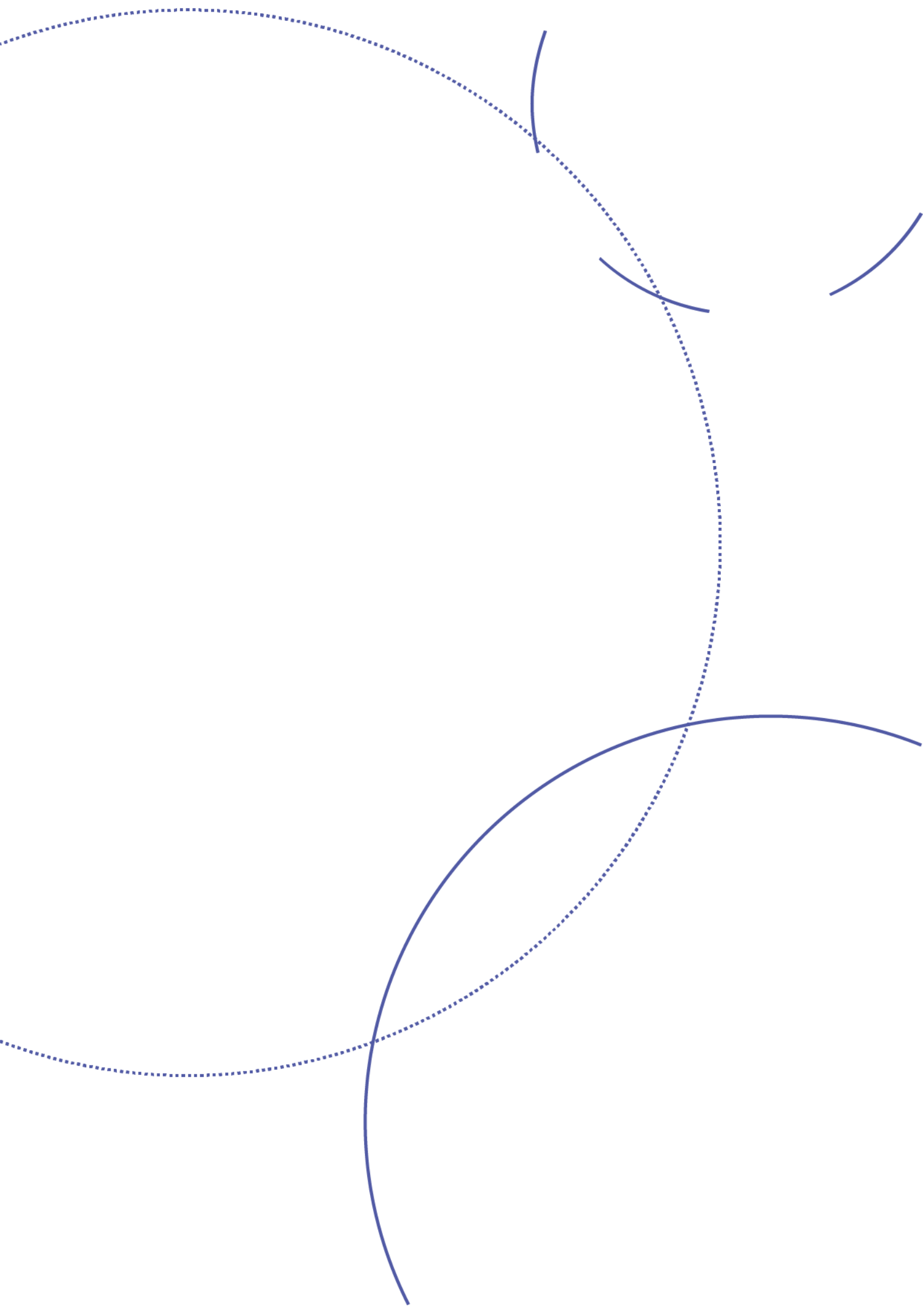
Improving
Policing
Across
Scotland



Custody inspection report Edinburgh

May 2026







HM Inspectorate of Constabulary in Scotland

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

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










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

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

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



Contents

	Page
 Our inspection	3
 Key findings	5
 Recommendations	8
 Areas for improvement	10
 Previous recommendations	11
 Context	12
 Methodology	15
 Outcomes	16
 Healthcare	38



Our inspection

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.

Following completion of the baseline review, we commenced a programme of joint custody inspections and, to date, have published nine custody inspection reports. The findings from these can be found on our [website](#). In March 2025 we 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 custody inspections.

This report relates to our inspection of St Leonards custody centre, the primary custody facility serving Edinburgh division, alongside Midlothian and East Lothian within the Lothians and Scottish Borders division. The inspection was carried out jointly by HMICS and HIS and focused on assessing the treatment of, and conditions for, individuals detained in police custody, as well as the effectiveness of custody operations and healthcare provision.

The onsite phase of the inspection took place in September 2025. Inspectors examined Police Scotland National Custody System (NCS) records and reviewed a representative sample of detainees processed during August 2025. We assessed the physical environment, including cells and healthcare facilities, and observed key custody processes. Inspectors also engaged directly with detainees, custody staff and healthcare professionals.

The inspection identified a number of findings consistent with themes emerging from previous custody inspections. We have referenced these within the body of this report where relevant. In particular, concerns remain around consistency in recording on the NCS, including significant gaps in the documentation of observations, meals, handovers, healthcare interactions, care planning and legal rights. In some cases, care plans did not adequately reflect assessed risks, and delays in recording observations persisted.



We found widespread reliance on generic, copy and paste entries which undermined the quality, reliability and value of custody records. Although strengthened scrutiny arrangements, including the creation of a new CJSD audit and compliance post, were acknowledged, overall audit coverage remained limited in relation to national custody throughput.

The centre had clear staffing challenges and, as outlined within our report, these can impact on the effectiveness and timely completion of routine custody tasks. Limited management visibility was also raised by staff, with implications for oversight of custody centre operations.

There was evidence of improvement in the management of children in custody, with no children placed in cells and no unnecessary detention following decisions to release. This reflects significant progress and presents an opportunity for the sharing of good practice across the custody estate relevant to the approach taken at St Leonards.

The report makes a series of recommendations aimed at improving operational effectiveness, recording standards, risk management, confidentiality, and governance arrangements. It also includes a number of healthcare-specific recommendations addressing training compliance, infection prevention and control, medicines management and the custodial care environment. These recommendations are directed at both Police Scotland and NHS Lothian.

We wish to thank the officers and staff from CJSD and local policing, as well as staff from NHS Lothian responsible for the delivery of healthcare at the centre.

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

Craig Naylor

His Majesty's Chief Inspector of Constabulary

May 2026



Key findings

- St Leonards custody centre serves Edinburgh (E) Division and the local area commands of Midlothian and East Lothian in Lothians and Scottish Borders (J) division.
- Some custody staff considered that the organisation was not responding effectively to ongoing pressures within the custody environment. Visibility and engagement from senior management was referred to as limited, with contact largely confined to first-line supervision.
- Custody staff, including supervisors, were unfamiliar with the content or location of the Business Continuity Management Plan (BCMP). Operational continuity appeared to be based on informal assumptions rather than documented local contingency arrangements.
- Staff demonstrated a clear understanding of the distinct roles of custody sergeants and CJPCSO team leaders. Proactive steps were taken to ensure clarity when new team leaders commenced, which inspectors assessed as positive practice.
- Recently upgraded charge bar facilities were bright and spacious and intended to increase processing capacity. However, confidentiality during detainee processing was limited due to the layout and noise levels, with conversations audible to others.
- Queuing at custody centres by arresting officers with detainees was common. While the three-charge-bar model was well intentioned, staffing levels meant that all charge bars were rarely operated simultaneously, resulting in delays and negative feedback from detainees and escorting officers.
- Staff highlighted inefficiencies arising from poor integration of police IT systems, resulting in repeated data entry and increased risk of error. These issues were compounded by staffing pressures, system limitations, spontaneous incidents and the absence of sufficient mobile IT devices. The removal of electronic tablets was viewed negatively by some staff.



- Local policing officers described custody staff as helpful and accommodating. However, limited staffing resilience within custody was acknowledged as adversely affecting morale, with processing frequently experienced as lengthy and arduous.
- Detainee hygiene provision was limited to hand and face washing facilities, including at weekends. Although acknowledged by staff as being less than desired, this practice had become normalised and was corroborated by independent custody visitors.
- In August 2025, 809 NCS custody records were created, of which 81 were reviewed by inspectors. The average detention period was 13 hours and 29 minutes, consistent with national figures.
- Children were managed appropriately: none were placed in cells, the longest detention period was under five hours, and CRI oversight of children in custody showed improvement. Inspectors also found no cases where detainees were held unnecessarily following a decision to release, indicating improvement from previous inspections.
- CRI oversight had strengthened, with comments recorded in 18 records reviewed, relating to extension reviews, dip sampling and child-focused scrutiny, which inspectors viewed as positive practice.
- Compliance issues remained. In one case, a detainee's refusal to engage on legal rights was not revisited before release. In three cases where a solicitor was requested, there was no evidence that contact had been made.
- Forty records were assessed as high risk but initially managed under level-one observations. In five cases, care plans were escalated promptly following supervisory review, however, a third of cases lacked documented risk mitigation measures.
- Care plans and handovers routinely lacked case-specific detail. Records frequently relied on generic, copy-and-paste entries placed in free-text notes rather than designated sections, diminishing their evidential and operational value.



- Delays in recording observation visits on NCS persisted, with an average delay of 17 minutes and a maximum delay of 45 minutes.
- All custody staff interviewed reported that the custody centre was understaffed, with limited resilience, which routinely compromised task completion.
- Healthcare management and oversight was provided through NHS Lothian's Royal Edinburgh Hospital and Associated Services (REAS) governance structures. Twice-daily staff huddles, that included NHS Lothians courts liaison service, supported safe and coordinated care by enabling timely information sharing and joint decision-making for vulnerable individuals. Regular engagement with Police Scotland and structured governance meetings ensured accountability and service alignment.
- The most recent IPC audit did not identify any issues with the environment. However, the audit process was ineffective as damage was clearly visible to the walls, flooring and to woodwork around the hand wash basin in the treatment room. It was unclear from speaking with healthcare staff if this damage had been reported to Police Scotland who are responsible for carrying out repairs to the environment, including the treatment room.
- Custody and healthcare staff appropriately referred detainees to addiction and outreach services, including Change Grow Live, Turning Point and Apex. Inspectors observed evidence of referrals, signposting and access to naloxone when nursing staff were on site.



Recommendations

Recommendation 1

Police Scotland should examine concerns raised resulting from the configuration of the holding room and introduce appropriate risk management arrangements to mitigate risks identified.

Recommendation 2

Police Scotland should take steps to address repeated manual data entry across multiple platforms to reduce repetition and improve efficiency.

Recommendation 3

Police Scotland should ensure that custody supervisors conduct effective handovers in relation to criminal justice decisions and care plans, and that such discussions are accurately recorded on the National Custody System.

Recommendation 4

NHS Lothian should ensure staff are compliant with their mandatory training.

Recommendation 5

NHS Lothian should ensure that IPC audits are completed in a way that reliably identifies damage to the care environment and that repairs are carried out to allow effective cleaning and decontamination.

Recommendation 6

Police Scotland should ensure that clinical waste bags are securely stored.

Recommendation 7

NHS Lothian should ensure staff are compliant with Immediate Life Support training.



Recommendation 8

Police Scotland should ensure that custody staff follow Criminal Justice Service Division guidance in relation to maintaining confidentiality when patients are undergoing interventions and treatments by the healthcare team.

Recommendation 9

NHS Lothian should review the Standard Operating Procedures related to medicines management to ensure that guidance on the safe and effective use of medicines is clearly defined. Healthcare staff must adhere to the Standard Operating Procedures in place.

Recommendation 10

NHS Lothian should ensure that compliance aids are labelled in accordance with legal requirements, including correct administration guidance and appropriate warnings.



Areas for improvement

Areas for improvement	Page number
The custody centre should explore options to mitigate environmental noise to ensure compliance with workplace noise regulations and improve information integrity and confidentiality during exchanges at custody charge bars.	1
The custody centre should explore options to improve the kitchen water boiling and cooling facilities so it can better accommodate the needs of the centre and improve operational efficiency.	2
The custody centre should reaffirm the expectations of custody staff regarding the offering of washes to detainees to ensure suitable access to personal hygiene facilities is afforded to detainees wherever practicable.	3
Police Scotland should ensure custody supervisory staff are fully conversant with the location and content of Business Continuity Management Plans relevant to their business area.	4



Previous recommendations

The following provides an outline of recommendations that we have made in previous custody inspection reports, which continue to have equally significant relevance for Edinburgh custody centre. These have been highlighted within this report where relevant.

Custody inspection report (Recommendation number)	Recommendation date	Paragraph reference
Lanarkshire (2)	20 April 2023	29
Dumfries and Galloway (2)	08 November 2023	112
Greater Glasgow (1) (2)	06 March 2025	58 , 55
Fife (5) (6)	28 March 2024	87 , 90
Highland & Islands (1)	26 November 2025	109



Context

1. Custody is delivered throughout Scotland by the Police Scotland Criminal Justice Services Division (CJSD). This division is one of several national divisions which sit alongside and support the thirteen local policing divisions. Custody is delivered in accordance with the care and welfare in police custody standard operating procedure, which is updated and amended regularly to reflect changes in practice guidelines and expectations.
2. National custody throughput fell to a relatively low level due to the Covid-19 pandemic, however, this has increased in recent years as indicated in the table below. The annual throughput at St Leonards custody centre has reduced in the past year, however the reason for this is unclear.

Table 1 – National custody throughput¹

Year	2020-21	2021-22	2022-23	2023-24	2024-25
Throughput	87408	84010	96279	99986	99219

Table 2 – Custody centre cell capacity and throughput

Custody centre	Number of cells	2022-23	2023-24	2024-25
St Leonards, Edinburgh	34	7484	8984	7157

*It is important to note that the number of arrested persons includes individuals who have appeared in custody on more than one occasion within the reporting period. This excludes voluntary attendance, S.23 MDA 1971 detentions, those in transit and rejected arrests. This is in line with published figures.

3. Custody centres in Scotland are organised into clusters, each led by a cluster inspector. Cluster five covers Edinburgh and the Lothians and Borders divisions and uniquely, has two cluster inspectors, one for Edinburgh and another covering Livingston and Hawick. There is one chief inspector for the CJSD east command area.

¹ Annual throughput data differs from that previously reported. This is because Police Scotland have adopted new audit software and data recording rules.



4. Edinburgh sits within the sheriffdom of Lothian and Borders. Detainees from Edinburgh, Midlothian and East Lothian are all processed at St Leonards custody centre and are served by Edinburgh sheriff court.
5. Healthcare management and oversight was provided through NHS Lothian's Royal Edinburgh Hospital and Associated Services (REAS) governance structures.
6. There are small ancillary centres at Drylaw and Craigmillar in Edinburgh, however these are very rarely used and then only for pre-planned detentions. There is an ancillary centre at Dalkeith in Midlothian, which is also only used for pre-planned activity. Dalkeith is the designated business continuity facility.
7. St Leonards custody centre has five teams each having an establishment of two sergeants, one team leader, two constables and four Criminal Justice Police Custody and Security officers (CJPCSO) who observe the CJSD 222b² shift pattern. The minimum staffing requirement for the centre off peak was two supervisors, at least one sergeant with a second sergeant or team leader, plus four staff, constables or CJPCSOs. At peak times that rises to one additional staff member. At the time of our inspection there was a total of seven vacancies, one sergeant, two constables and four CJPCSOs.
8. We were informed that CJSD strategy is currently being reviewed following the introduction of the Police Scotland 2030 custody project. Current strategic aims are to improve communication with local policing regarding the provisions of the Criminal Justice Act (2016). The appointment of a new audit and compliance sergeant has improved communication between CJSD and local policing and, with the input of custody review inspectors, has increased to a degree, the level of scrutiny applied to custody delivery. While this increased evaluation represents an improvement on previous methodology, case sampling remains relatively modest compared to the total volume of national custody throughput.

² The CJSD 222b pattern relates to custody staff working two early shifts, two late shifts and two nights, followed by four non-working days.



Independent custody visitors

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

10. During our inspection, we reviewed the ICVS service book that is completed following each visit by the custody visitors. This reflected a pattern of recent and regular visits at Edinburgh custody centre. There were notes relating to several detainees who had been interviewed by ICVS staff, who reported they had not been offered the opportunity to wash and/or shower during their period in police custody.



Methodology

11. HMICS and HIS undertook a wide range of activities during the baseline review of healthcare provision in custody to inform the development of our custody inspection methodology. These activities are outlined in the aforementioned report published in January 2023. As a result, the following key stages have been undertaken for this inspection and will form the basis of future joint inspections.
12. HIS requested that the NHS board complete a self-evaluation document and submit key evidence to help inform the planning of the onsite inspection. Inspectors offered a pre-meeting teleconference with healthcare staff before the site visit to provide an outline of the inspection process.
13. During the inspection, we examined the treatment of, and conditions for, detainees at the centres. We observed key custody processes and assessed the custody environment, condition of cells and facilities for detainees. We undertook interviews with custody staff and managers, as well as healthcare practitioners (HCP) that were present during our visit. We also spoke with people detained in custody at the time.
14. A proportionate sample of custody records were examined from those recorded at St Leonards custody centre during the period of August 2025. The total sample numbered eight hundred and nine, and eighty-one records were inspected. This represents ten percent of the total.
15. The sample was selected to be broadly representative of the proportions of men, women and children held in custody during the aforementioned period. Based upon this, sampling was weighted to ensure that women and children were included during random selection.
16. The review of NCS records provided valuable information on aspects of risk assessment, observation levels, and compliance with Police Scotland's care and welfare standards.



Outcomes

Custody centre condition and facilities

17. St Leonards has operated as a custody centre since 1990, initially under the former Lothian and Borders Police Force and subsequently under Police Scotland from April 2013. The centre serves Edinburgh (E) Division and the local area commands of Midlothian and East Lothian within Lothians and Scottish Borders (J) Division. Ancillary custody centres at Craigmillar and Drylaw are rarely used, with Dalkeith occasionally opened for operational or business continuity purposes. St Leonards remains one of the busiest custody centres in Scotland.
18. The custody centre occupies a single storey layout integrated into the footprint of the adjoining operational police station. Inspectors found that all custody facilities were operational at the time of inspection. Operational cells were in good physical condition, with no significant defects or visible ligature hazards identified.
19. Inspectors examined the secure dock and rear yard used for detainee arrivals. The dock can accommodate only small vehicles and is accessed via a constrained rear compound that also serves as parking for operational and personal vehicles. Staff reported that this space is routinely tested when large custody transport vehicles require to manoeuvre during detainee transports.
20. The rear yard is accessed directly from the public road and is bounded by a relatively low wall, with no additional security features to prevent entry or egress. A manually operated swing gate was reported by staff to be rarely closed. Although the area is monitored remotely via CCTV from the custody office, staff described frequent breaches of the compound and reliance on increased vigilance to mitigate associated risks. Inspectors recognise this as a longstanding architectural issue.



21. As outlined in our report on the joint inspection of primary custody centres in Argyll and West Dunbartonshire, we have identified areas for improvement which have relevance across the custody estate. One such area identified from this report stated:

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

While this has relevance for St Leonards custody centre, we do not intend to make additional recommendations or areas for improvement in this regard.

22. The vehicle dock and the adjacent car park is, however, covered by numerous CCTV cameras remotely operated and monitored from the custody suite. There were two prominent “Police vehicles only” signs located on the low wall at the entry point from the public road. The rear compounds of all facilities were free of unnecessary or hazardous items.
23. St Leonards features a detainee holding room, recently added to the complex and located opposite the charge bar area. Inspectors identified safety and operational concerns associated with the configuration of this space. The narrow layout frequently resulted in congestion when accommodating multiple detainees alongside the required number of escorting officers.
24. Staff described incidents since the opening of this facility in which disorderly or incapacitated detainees obstructed exit routes, leading to unwanted physical contact and, on one occasion, a physical assault on a member of staff who was rendering assistance.



25. Inspectors found that the positioning of CCTV cameras within the holding room resulted in blind spots created by fixed concrete dividers. This limited effective monitoring of unprocessed detainees who had yet to be fully searched, unless they were being directly observed by escorting officers. Only a limited portion of the holding room was directly viewable from the main charge bars.

Recommendation 1

Police Scotland should examine concerns raised resulting from the configuration of the holding room and introduce appropriate risk management arrangements to mitigate risks identified.

26. The custody centre benefits from three recently refurbished charge bars intended to increase processing capacity. A separate bespoke discrete charge bar provides enhanced privacy for vulnerable detainees, including children, which inspectors regarded as good practice. Induction loop facilities were also available, supporting accessibility.
27. Despite these improvements, inspectors observed that confidentiality during booking in was compromised by ambient noise and layout, with discussions readily audible to others, including detainees in adjacent areas.

Area for improvement 1

The custody centre should explore options to mitigate environmental noise to ensure compliance with workplace noise regulations and improve information integrity and confidentiality during exchanges at custody charge bars.

28. The processing area including holding area were suitably equipped with safety materials, first aid, defibrillator, fire safety equipment and metal detectors and audio recording at all charge bars and cameras capture the charge bar desktop to record personal property being logged and bagged. Fire alarm tests are routinely conducted; however, fire drills were predominantly verbal walk-throughs rather than physical evacuation drills in line with regulations.



29. As outlined in our report on the joint inspection of primary custody centres in Lanarkshire, we have made recommendations that have relevance across the custody estate. **Recommendation 2** from this report stated:

“Police Scotland should ensure that a full evacuation of custody centres is undertaken in accordance with fire safety regulations.”

While these issues have relevance for St Leonards custody centre, we do not intend to make additional recommendations or areas for improvement in this regard.

30. The charge bar area afforded convenient access to the custody staff office and wider custody centre via a single connecting corridor. These areas housed additional facilities such as detainee engagement and interview rooms, well-appointed medical examination rooms, multiple storerooms, photograph and impressions rooms, and forensic storage.
31. There were three separate shower facilities located in each of the cell corridors. The main wash area was located in the central corridor and consisted of a shower and two sinks located on each side of the cell corridor. In each of the two adjacent corridors was a single shower and double sink. The shower trays were high lipped stainless steel base units which were not wheelchair accessible. There was a basic waist level modesty wall.
32. Additionally, there was a standalone wet room toilet shower located off the main cell access corridor which was wheelchair accessible. The water supply for the sinks, showers and in-cell basins was fully functional with hot water on demand. Ample washing materials and feminine hygiene products are available throughout the facility.
33. The centre had access to multiple interview rooms located in a separate secure corridor accessed from the main custody suite. The rooms were artificially and naturally lit and well-ventilated with secured desks but insecure seats. There were affray bars in the interview room corridor.



34. The custody staff office was a reasonable size with ample workspaces and conveniently located next to the charge bars, cell complex and sergeant's office. The office contained wall mounted CCTV screens displaying clear images of external security points and images from the cells. Screens were well-placed, adjustable and capable of being seen from all workspaces.
35. CCTV coverage across the custody centre was extensive and generally effective. However, inspectors found that the relatively small monitoring screens in the main custody office reduced staff's ability to accurately discern potentially harmful or concerning activity when multiple detainee images were displayed simultaneously.
36. Following refurbishment of the cell corridors, detainee property storage was relocated to several separate spaces elsewhere within the station footprint. Staff reported that this arrangement introduced unnecessary inconvenience and extended detainee processing times.
37. Kitchen facilities within the custody suite were extremely limited for the centre's throughput. Staff reported that the water boiler was insufficient to meet demand, taking up to 45 minutes to refill, and that the water cooling system frequently malfunctioned. As a result, staff relied on kettles and improvised cooling arrangements, which adversely affected operational efficiency.

Area for improvement 2

The custody centre should explore options to improve the kitchen water boiling and cooling facilities so it can better accommodate the needs of the centre and improve operational efficiency.

38. A large staff breakout room and adjacent standalone kitchen was available to all occupants of the station although this was also used on occasion by custody staff. This was located adjacent to the custody supervisor's office within easy access to the custody suite.



39. The centre was adequately provisioned with well situated and fully functional CCTV cameras linked to the charge bar and staff offices. Staff were not issued with personal alarms, however, the majority of wall surfaces and adjacent rooms were fitted with multiple affray panels, the activation of which will activate a loud siren and blue flashing light audible throughout the centre. These panels were easily accessible, highly visible, and linked to a central control panel located in the custody office. Affray panels were subject of a regular testing regime.

Condition of cells

40. Inspectors found the cells examined to be in good physical condition, with no notable defects or evident ligature hazards identified. Three cells were closed due to minor faults, which had been recorded by supervisors for remedial action.
41. Cells were distributed across three corridors. The first corridor contained nine cells. The second corridor contained eleven cells, with fourteen cells located in the third corridor.
42. There were no dedicated dry cells, although toilet covers were available when required. Two former multi-occupancy cells had been repurposed as storage areas.
43. All cells were wheelchair accessible; however, only one cell had additional adaptations to support enhanced accessibility needs. The cells had call buttons but no intercom, and these were linked to the charge bar and staff office. Those available for inspection were tested and were fully operational.
44. Cells were equipped with low sleeping plinths, artificial and natural lighting, smoke detectors, functional CCTV and modern cell doors with service hatches, peep slots and slam locks.
45. Weekly cell checks were conducted by custody staff, including checks of Automated External Defibrillator (AED) equipment. Any issues identified were recorded electronically and on the custody office whiteboard and addressed under the direction of the custody supervisor.
46. Cleaning services were provided seven days per week by police appointed cleaners. Where cells were vacated outside cleaner attendance and operational demand required immediate reuse, custody staff undertook cleaning duties.



Custody centre staffing

47. Custody staff demonstrated a clear understanding of the distinct roles of custody sergeants and CJPCSO team leaders. Proactive steps were taken locally to ensure clarity when new team leaders commenced, which inspectors assessed as positive practice.
48. The cluster inspector covering St Leonards custody centre reports to the CJSD chief inspector for east based centres, who in turn reports to a national CJSD operations superintendent. Despite this structure, several staff were unaware of divisional leadership arrangements or wider strategic priorities.
49. Inspectors identified limited visibility and engagement from senior management, with staff reporting contact largely confined to first line supervision. Some staff expressed concern that the organisation was not responding effectively to pressures within the custody environment.
50. Staff described the custody centre as significantly understaffed, with very limited resilience. Inspectors found that staffing pressures could compromise routine task completion, including the provision of showers and time spent with detainees.
51. Inspectors examined the national custody staffing model, which broadly allocates one sergeant and one staff member per ten detainees based on cell capacity. Inspectors noted that this approach did not adequately reflect throughput demand nor the workload associated with booking in, processing and release.
52. At the time of inspection, night shift staffing consisted of four staff, including two supervisors and two CJPCSOs. Staff reported that this offered limited resilience and increased vulnerability during spontaneous incidents.
53. Staff highlighted challenges associated with sickness absence, restricted duties and the impact of mandatory body armour requirements. Some staff on restricted duties were unable to assist at the charge bar, while delays in body armour provision restricted the operational deployment of new appointees. Inspectors noted that this issue was under review at the time of inspection.



54. Staff also reported limited ability to take breaks. Early termination of duty had become a common mitigation for missed breaks, although staff stated this was increasingly denied due to already low staffing levels.
55. As outlined in our report on the joint inspection of primary custody centres in Greater Glasgow, we have made recommendations that have relevance across the custody estate. **Recommendation 2** from that report states that:

“Police Scotland should ensure that an appropriate level of management presence is maintained at custody centres in order to improve the quality and consistency of operational practice and to ensure compliance with approved protocols and standards.”

While this has relevance for St Leonards custody centre, we do not intend to make an additional recommendation in this regard.

56. A custody supervisor stated that there is significant inconsistency between the effectiveness of the Resource Deployment Unit covering Edinburgh compared to that servicing the West of the country with staff widely reporting concerns regarding ensuring shifts were planned and covered in advance, poor management of absence and restricted duties, and late notice provided for relocation of staff.
57. Staff highlighted that the level of care provided to detainees was not to the standard they would like to see, or that detainees deserve. They cited gaps in staffing levels as being the main reason for this, which is a sentiment common at other centres visited by inspectors. Consideration should therefore be given to reviewing the rationale for the existing staffing model to ensure it remains suitable and fit for purpose.
58. As outlined in our report on the joint inspection of primary custody centres in Greater Glasgow, we have made recommendations that have relevance across the custody estate. **Recommendation 1** of that report stated:

“Police Scotland should examine the staffing levels at the custody centres in Glasgow and make arrangements to ensure that appropriate staff resource is in place to maintain safe and effective custody centre operations.”

While this has relevance for St Leonards custody centre, we do not intend to make an additional recommendation in this regard.



Arrival at custody and booking-in process

59. When a detainee arrives at a custody centre, the arresting officer must discuss the circumstances of the arrest with a custody sergeant, who in turn must record a written rationale to explain if the arrest is necessary and proportionate and is subsequently authorised or not. Background checks are sometimes carried out prior to commencing the booking in and speed of booking can be influenced by how many detainees are waiting and the availability of custody staff.
60. The arrival time is a manual entry and is the time at which the arresting officers say they arrived, whereas the authorisation time is a computer time stamp at the start of data input. There is an assumption that the arrival time is recorded accurately although it is accepted that this could, at times, be incorrect. The average time of waiting in the sample was 54 minutes, which is comparable to other large urban custody centres but higher than waiting times observed elsewhere.
61. A correlation can be drawn that the busiest custody centres in Scotland, such as those in Edinburgh and Glasgow, have the longest queues. Edinburgh has a single custody centre for a large area. Although multiple charge bars were available, the single-entry model and staffing constraints can create a bottleneck effect during peak demand.
62. Inspectors identified significant inefficiencies arising from poor integration between police IT systems, resulting in repeated manual data entry across multiple platforms and increased risk of error. Custody staff stated that considerable time could be saved by improving the integration of the various platforms to avoid repetition.

Recommendation 2

Police Scotland should take steps to address repeated manual data entry across multiple platforms to reduce repetition and improve efficiency.



Legal rights

63. Part of a custody sergeant's role is to record the necessity and proportionality of arrest under the Criminal Justice (Scotland) Act 2016, giving due consideration to the Lord Advocates Guidelines (LAG), and to apply a rationale for that and any subsequent criminal justice decision making. The final decision for the sergeant, is to consider the disposal for each detainee and accompany that with a detailed rationale recorded on the NCS.
64. Of the detainees we observed, and those we examined on the NCS, the disposal decisions recorded by sergeants were consistently good, appropriate and in many cases accompanied with detailed rationale. Some were very detailed and of a very high standard. This is reflected nationally and can potentially be attributed to a period of very intrusive scrutiny in the years following the Covid-19 pandemic.
65. All detainees should be offered a letter of rights leaflet and the NCS updated to reflect if accepted or declined. The offer of a letter of rights was accepted in 42 cases. We saw occasions when a letter of rights was provided in an easy read format and in a foreign language.
66. As part of the booking process every detainee is asked if they wish for intimation of their arrest to be passed to a solicitor and, in many cases, this was accurately recorded. There were three records where a solicitor had been requested, however there was no record of a solicitor being contacted. While this could be a recording error, inspectors could not be assured that legislative requirements were adhered to.
67. Notification to a reasonably named person was requested in 21 records within our sample. This included contact made with parents in the case of child detainees and there were notes to explain that contact was made or attempted. There was evidence that repeated attempts were made to contact reasonably named persons where necessary.
68. The Police Interview - Rights of Suspects (PIRoS) form is only completed when a detainee is to be interviewed as a suspect. Where a detainee has been arrested as officially accused, or is not interviewed, it is unlikely that a PIRoS will be recorded. Within the sample of records we examined, PIRoS was recorded correctly.



69. Inspectors reviewed four records relating to children aged fifteen or under. All records had notification to a reasonably named person to act as an appropriate adult. Three of the four records had evidence of supervisory oversight in the form of comments added by the Custody Review Inspector (CRI), which we consider to be good practice.
70. None of the children were placed in cells and were always escorted by police officers, which we also consider to be good practice. The longest period in custody for a younger child was four and a half hours, which is a positive development given the longer periods we have identified at other centres.
71. Only those who are arrested as not officially accused, or under suspicion, must be reviewed by the CRI – with reviews taking place at six, twelve and eighteen hours. These reviews require that investigation is diligent and expeditious. After an investigation is complete, a detainee's status may change to 'officially accused'. An officially accused person in custody is not necessarily monitored by the CRI however since the removal of the Force Custody inspector (FCI) role, there is greater CRI scrutiny where time permits.
72. In contrast to previous inspections, we saw CRI comments added to eighteen of the records reviewed, which is far greater. This related to a mixture of extension reviews, dip sampling and child reviews. We consider this to be good practice.
73. The rationale in relation to disposal decisions was largely good. There was one instance where the rationale and disposal information for an undertaking was absent and another where there was no information relating to a release without charge. We saw some records where there was very detailed disposal information and some with very minimal information. We were able to determine that this variation was dependent on the individual adding the information. Divisional training and compliance audit processes should encourage greater quality and consistency.
74. The average period of detention of all detainees held in August 2025 at St Leonards was 13 hours and 29 minutes, similar to our findings on other custody inspections. The figures across Scotland are largely consistent.



75. In contrast to other custody inspections, we saw no instances where a detainee was unnecessarily held beyond the time when a disposal decision was made to release them, without there being a suitable rationale. Some records explained that it was necessary for the detainee to be less intoxicated prior to release to reduce the risk of re-offending, or where some needed medical attention. We consider the explicit recording of these decisions to be good practice.
76. Detainees are assessed prior to release and asked two pre-release risk assessment (PRRA) questions prior to leaving, regardless of their status. These relate to whether or not the individual has any thoughts of self-harm or suicide, or thoughts of harming anyone else. The PRRA was completed in all cases, and all responses were negative.
77. When a detainee is transferred to GEOAmev to be escorted to court, custody staff must complete a person escort record. This form is important in that it informs the escort provider of any identified health issues and any other identified risks that a detainee may have to ensure their ongoing care. We examined a sample of these and found them to have been completed to a good standard.

Risk assessment and care plans

78. During the booking-in process, a risk assessment is carried out for all new arrivals to police custody. Detainees are asked a range of questions by custody staff based on a pre-determined vulnerability questionnaire. The purpose of the questionnaire is to identify past or present issues in relation to physical and mental health, substance use, self-harm, suicidal ideation or other vulnerabilities. These questions are personal in nature, however we saw that staff were sensitive and respectful in their approach and questionnaires were completed well.
79. Effective risk assessment is vital to ensure that detainees can be managed and cared for appropriately. We saw risk assessments and care plans being formulated through discussions between the CJPCSO and the team leader or sergeant.



80. The initial risk assessment process allows custody staff to determine a bespoke care plan for detainees and involves determining whether the person presents high or low risk and applying a corresponding level to determine the appropriate frequency of wellbeing observations. This approach is based on an assessment of threat, risk and vulnerability. Responses to the vulnerability questionnaire and the subsequent care plan should be recorded on NCS. Based on the outcome of the risk assessment, detainees are subject to observations and rousing³ in accordance with the following standardised scale:

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

³ Rousing involves gaining a comprehensive verbal response from a detainee, even if it involves waking them while sleeping. If a detainee cannot be roused, they should be treated as a medical emergency.



81. Team Leaders and supervisors have other tactical options to mitigate risk. For example, a referral can be made to a healthcare provider, the detainee can be provided with anti-harm clothing or can be placed on enhanced observations. Enhanced observations means that the cell CCTV images are streamed live to a monitor in the custody office for staff to view occasionally as they carry out other tasks. It is a less intrusive and resource intensive option compared to the above noted level 3 observations, although policy indicates that it should be accompanied by 15 or 30-minute observation cell visits.

82. From the sample of 81 records examined:

- 16% of detainees were intoxicated on arrival
- 33% had consumed alcohol and 23% had used drugs prior to arrest
- 14% declared they were alcoholics and 17% were drug dependent
- 38% were on prescribed medication
- 36% disclosed a mental health condition and 32% reported they had previously self-harmed or had attempted suicide
- 12% stated they had difficulty with reading and writing

Almost all detainees had some form of criminal or police information record.

83. Statistics relating to mental health are similar to those found on our previous custody inspections. Overall, there is a correlation between health, vulnerability and offending which is reasonably consistent across the country. It highlights the high level of risk, addiction, mental health, and medical health challenges presented to police custody daily.

84. In some records, we found that the vulnerability assessment had not been completed on arrival. This can occasionally occur if the detainee is uncooperative at that stage. In such circumstances the detainee would typically be considered as high risk with an appropriate care plan as the risks are unknown. However, in three records, the vulnerability assessment was not completed and was not revisited at a later stage.



85. Following completion of the vulnerability assessment it is the duty of the custody supervisor to decide if the risk is high or low. Of the sample, 69 were assessed as high risk and 12 were low risk. Forty of the records assessed as high risk had level 1 observations applied as the care plan, which seems incompatible. We have highlighted this anomaly in several previous inspection reports and have referred to the potential risks that this approach can introduce.

86. While we accept that there will be cases where it is appropriate to respond to an assessment of high risk with a lower level of care plan and observation level, it is essential to record a satisfactory rationale to explain such decisions.

87. As outlined in our report on the joint inspection of primary custody centres in Fife, we have made recommendations that have relevance across the custody estate.

Recommendation 5 of the report stated:

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

While this has relevance for St Leonards custody centre, we do not intend to make an additional recommendation in this regard.

88. We found that comments had been added to explain care plan decisions in several cases, however it was almost exclusively added in free text to the custody officers’ notes page rather than the observation page, which blocks pasting text. We noted that many records had paragraphs added that were identical in format, evidently copied and pasted with some details adjusted. We noted one care plan that was generic in style that had been repeated without alteration across five records. It included no detail specific to the case in question and provided no value.

89. There were four records that had no care plan and four records with a care plan produced by a staff member that had not been endorsed by a supervisor.



90. As outlined in our report on the joint inspection of primary custody centres in Fife, we have made recommendations that have relevance across the custody estate.

Recommendation 6 of the report stated:

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

While this has relevance for St Leonards custody centre, we do not intend to make an additional recommendation in this regard.

91. There were 22 records where the observation level was changed during the period of detention. Each had a brief explanation to explain that time had elapsed, that the detainee was more receptive, or that they had been seen by a healthcare professional as evidence to support the change. We consider this dynamic review process to be good practice.
92. Observation visits and the provision of food, drinks, blankets, pillows and books, when requested, are generally carried out by CJPCSOs. Such activity should be recorded on the NCS. As at other custody centres, staff make a note of each transaction and then update information onto the NCS when they return to the office, which can take some time depending on any interruptions. This delay in recording can lead to omissions of information, inaccuracy in the detail, and can raise questions about the integrity of recorded information.
93. We checked the time difference between the actual cell visit time logged on the NCS and the time stamp relating to when it was recorded on NCS, recording the quickest and longest updates. Most quick updates were completed within several minutes and observations were logged appropriately in 36 records. Of the remainder, the longest delay to update NCS was 45 minutes.
94. This matter has been the subject of previous HMICS recommendations where the ability to make contemporaneous records of interactions with detainees using an electronic tablet was considered good practice.



95. Custody staff reported that accurate recording is compromised by staffing levels, spontaneous incidents occurring, the limitations of the NCS and the continued lack of IT devices to record live-time interventions. One staff member stated the use of electronic tablets had been successfully demonstrated and that they would be an asset if used.
96. When an arrested person is brought to a police station they should always be searched. Often this search is limited to clothing and pockets, known as a standard search, but there may be occasions where it is appropriate that the search involves the removal of the detainees' clothing, referred to as strip searches. These should be conducted in as dignified manner as far as is possible and must be authorised by a sergeant based on risk, necessity, and proportionality.
97. Forty four records indicated that detainees were subjected to a standard search. A strip search was recorded in 27 instances, each authorised by a sergeant or inspector. Some records had very good rationales added to justify the necessity to strip search a detainee, some had inadequate comments, some being one word e.g. "drugs". Any decision to strip search a detainee should be accompanied by a clear and specific rationale.
98. Supervisors described an existing handover process that is carried out by the CJPCSO team leaders and consists of a typed care and welfare sheet for each detainee. This is a worthwhile practice as it ensures a degree of management and understanding of the individual care and welfare needs of respective detainees. However, this record, given it is not a function of NCS, is routinely deleted at the conclusion of the shift thereby erasing opportunities for reflective learning.
99. On a backshift, the sergeant and CJPCSO team leader start at different times and therefore a single handover does not take place. It is incumbent on the latter to liaise with the sergeant to establish any issues of note and/or to interrogate NCS or review the whiteboard in the main office, which should highlight any key risks that pertain to detainees.



100. We found that a handover had been recorded in 59 records examined. However, in almost all of these, the care and welfare handover entries on NCS were generic and largely copied and pasted from record to record. They contained no case specific information and merely stated that the existing risks were acknowledged and accepted and then detailed the staff who were on duty.
101. This manner of handover recording offers little value. It provides no confidence that the supervisor has actively reviewed the care plan or is taking steps to ensure that ongoing care is appropriate to the detainees needs. Some staff members stated this practice has led to errors and incorrect personal information being added to records.

Recommendation 3

Police Scotland should ensure that custody supervisors conduct effective handovers in relation to criminal justice decisions and care plans, and that such discussions are accurately recorded on the National Custody System.

Detainee care

102. When a decision is made that a healthcare professional (HCP) is required, custody staff should update the risk assessment page on the NCS, ticking a box. This generates a flashing green cross at the top of the record to remind staff that medical attention is required. A call must then be made to the healthcare provider. Once a detainee is seen, a summary of the medical review should be added to the NCS in the form of a medical assessment page, and the 'medic required' tick box should be cancelled.
103. Referral to a healthcare professional (HCP) was made in 39 of the cases reviewed and the detainee was seen on 30 occasions. We saw delays between the time that a detainee was "booked on" to see an HCP on the NCS and when the medical update was added. There were delays of more than five hours in 11 cases and ten hours in six cases – with the longest being 21 hours. However, having examined the circumstances surrounding the issue we found that this most likely reflects a delay in closing the request on the NCS system, rather than a delay in the detainee being seen by a HCP.



104. There were two records where the medic box was not ticked but free text indicated a medic was contacted. There were seven records where the box was ticked but not later cleared, leaving the green cross activated. This has the potential to cause confusion or uncertainty for staff joining a later shift regarding whether or not the detainee had been seen.
105. Fifty seven of the records sampled indicated that meals were provided. There were 22 records where no meal was recorded and, of those, we consider that it should have been provided in six cases. The offer of a drink was recorded in 54 records and there was no note of a drink being provided in 27 records. These are likely to be recording errors.
106. Detainees were typically offered a wash in the morning prior to attending court. Those being released to return home are not generally offered a wash or shower although, if requested, this is accommodated where possible. In our review of records, of the 39 detainees held for court, there was no record of a wash being offered in 11 cases.
107. Staff interviews confirmed only hand and face washes were routinely offered to detainees, including over the weekend, which falls short of the standard expected. While staffing levels can contribute to this, one staff member stated that this had become common practice. Several detainees interviewed by ICVS staff had reported they had not been offered the opportunity to wash and/or shower during their period in police custody.

Area for improvement 3

The custody centre should reaffirm the expectations of custody staff regarding the offering of washes to detainees to ensure suitable access to personal hygiene facilities is afforded to detainees wherever practicable.



108. Images produced by the cell cameras were via fisheye lenses and, when isolated, provided an appropriate view of the detainee and cell space. The dedicated CCTV viewing facility was well equipped with appropriate monitoring screens. However, the relatively small general monitoring screen in the main staff office meant that when multiple cell images were brought up, each image was reduced in size to such an extent it rendered it extremely difficult to accurately distinguish potentially harmful or concerning activity from detainees. The screen should therefore be upgraded.
109. As outlined in our report on the joint inspection of primary custody centres in Highland and Islands, we have made recommendations that have relevance across the custody estate. **Recommendation 1** from that report states that:
- “Police Scotland should improve CCTV viewing equipment and conditions for officers ensure the location, number, and quality of screens is sufficient to provide clear imaging of detainee cells, including when displaying multiple camera feeds.”
- While this has relevance for St Leonards custody centre, we do not intend to make an additional recommendation in this regard.
110. Clothing was removed in four of the cases we reviewed. All related to the provision of anti-harm clothing as mitigation for risk of self-harm and, while the decisions correlated with risks, the rationale for use was not specifically explained in the care plans.
111. The lack of available appropriately sized anti-harm clothing remains a significant issue across the custody estate. This can impact on the dignity and safety of female or small stature detainees who regularly have to accept oversized baggy garments. There was no evidence that this issue was being effectively addressed by way of the service delivery protocols.
112. As outlined in our report on the joint inspection of primary custody centres in Dumfries and Galloway, we have made recommendations that have relevance across the custody estate. **Recommendation 2** from that report states that:
- “Police Scotland should ensure that sufficient and appropriately sized anti-harm garments are made available to detainees when these are required.”
- While this has relevance for St Leonards custody centre, we do not intend to make an additional recommendation in this regard.



Staff training

113. All custody staff are required to complete standard custody training, which is comprised of two mandatory courses, a custody officer induction course covering custody care and welfare lasting three days, and two days training on the NCS. Custody staff should also be trained in first aid, officer safety, fire safety, and data protection. Staff valued on the job training, learning with experienced colleagues but pointed out that there is no structured mentoring programme.
114. Some custody supervisors had received two days online supervisor training, which replaced the former two-week supervisors course delivered at the Scottish Police College. Concerns were raised by some staff that there is no specific team leader training; an issue that was highlighted in our report on the inspection of custody centres in Greater Glasgow. This represents a clear gap as they have no formal training in, for example, SCoPE absence management (and associated protocols). Leadership training is now delivered in three half-day online inputs rather than the former two week first-line supervisor's course.
115. Custody staff, including supervisors, were not aware of the location or content of the Business Continuity Management Plan (BCMP) for Edinburgh custody centre and appeared only to be operating on the assumption that other custody centres would accommodate Edinburgh detainees in the event of serious disruption to their operational capability.

Area for improvement 4

The custody centre should ensure custody supervisors are fully conversant with the location and content of Business Continuity Management Plans relevant to their business area.



Referral services

116. Detainees are routinely asked if they would like to be referred to an agency to support them with issues such as addiction or mental health. The provision of services differs from area to area, however NCS has a compulsory field that staff must update to indicate if the offer was accepted, declined or was not considered appropriate.

117. Our review of records found that the majority of referrals were made by NHS staff. Arrest referral services were offered and declined in 54 cases and recorded as not applicable in 25 cases, however in six of those, inspectors considered that a referral would have been appropriate as addiction issues were evident in the records.

118. The centre had five staff champions for the arrest referral process, for which they received NHS training on trauma based harm and how to conduct effective interviews with detainees. The staff champions provide information to detainees on available services such as Change Grow Live, Apex Scotland, Midlothian MELD, and the VOW project, which inspectors considered good practice. Inspectors saw evidence of healthcare staff making referrals to statutory addiction services and signposting patients to community support.



Healthcare

119. This section sets out the findings from Healthcare Improvement Scotland's (HIS) visit to St Leonards police custody centre on 30 September 2025. It includes an outline of current healthcare provision and identifies any areas of good practice and recommendations for improvement to help drive the quality of care and consistency in healthcare delivery. The inspection of healthcare focused on the health and wellbeing aspects of detainees as set out in the joint HIS/HMICS Framework to Inspect. The framework has been developed using a human rights-based approach which includes person-centred indicators. All components of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment are reflected in our inspection methodology.

How we carried out the inspection

120. The inspection was unannounced, however, to enable the NHS Lothian to undertake preparatory work, we provided the board advance notice that an inspection would take place at a future date.
121. During the inspection, HIS inspectors spoke with members of staff from healthcare as well as Police Scotland custody staff, and reviewed the care environment within the police custody centre. Inspectors also spoke with a small number of detainees during the inspection regarding their experience of healthcare. The onsite inspection team consisted of two inspectors and a Pharmacy Subject Matter Expert who provided support to the inspection team. Subject Matter Experts are individuals who join our inspection team to provide specialist healthcare opinion based on their area of expertise. Working under the direction of the lead inspector, the Subject Matter Expert is responsible for ensuring that their opinion of the healthcare being delivered during the inspection is informed by current practice, professional knowledge and experience.
122. We asked NHS Lothian to provide key evidence documents, and we held a teleconference with healthcare staff following the onsite visit to help inform our inspection findings.



Governance of Healthcare

123. St. Leonards sits within NHS Lothian, with healthcare delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service. This nurse-led service operates peripatetically across multiple custody centres, ensuring 24/7 coverage. Leadership is provided by a Clinical Nurse Manager (CNM).
124. Staffing levels were stable with no vacancies. However, at the time of inspection, the service was managing a high level of sickness absence effectively through internal escalation and flexible staffing arrangements. The team comprised both Adult Health Nurses (RGNs) and Registered Mental Health Nurses (RMNs), supported by Senior Charge Nurses (SCN) and on-call Forensic Physicians. Enabling responsive, needs-based care, this is considered good practice.
125. Healthcare management and oversight was provided through NHS Lothian's Royal Edinburgh Hospital and Associated Services (REAS) governance structures. Twice-daily staff huddles, that included NHS Lothians courts liaison service supported safe and coordinated care by enabling timely information sharing and joint decision-making for vulnerable individuals. This is considered good practice. Regular engagement with Police Scotland and structured governance meetings ensured accountability and service alignment.
126. The service demonstrated a proactive approach to quality assurance, completing audits and collecting data on different aspects of care delivery, including mental health assessments and harm reduction interventions. This data was discussed regularly at meetings within the REAS governance structure. This is considered good practice.
127. All staff had completed induction training, which included trauma-informed practice. While human rights-based training was also reported as completed by all staff, compliance with other mandatory training topics was variable. It is essential that staff are up to date with their mandatory training so that they can carry out their role safely and effectively.

Recommendation 4

NHS Lothian should ensure staff are compliant with their mandatory training.



128. The majority of staff had up-to-date Personal Development Plans (PDPs) and appraisals, reflecting a positive culture of professional development.
129. Not all nurses working in police custody had received training in Dried Blood Spot Testing (DBST), which was delivered by the NHS Lothian Blood Borne Virus (BBV) team. We were informed that dates for future training were being arranged. Although DBST was available, most of the testing was carried out via venepuncture, a method that can be more difficult to deliver in custody settings due to time constraints and clinical requirements. Additionally, some detainees may be reluctant to undergo blood testing, which could further impact uptake.
130. Five DATIX (risk management information system) reports were submitted in the past year, with learning shared through team meetings. Information on how to give feedback or make a complaint was displayed. No complaints had been received in the past year.
131. Although there was no dedicated Infection Prevention and Control (IPC) lead at St. Leonards, NHS Lothian's IPC team provided consistent and effective support through regular governance meetings and timely access to expert advice. All staff had completed IPC training, which was monitored and kept up to date, ensuring staff practiced in line with national standards. Local IPC audits were conducted regularly and mirrored NHS Lothian's audit programme, enabling IPC practice and the care environment to be monitored and also support continuous improvement. The National Infection Prevention and Control Manual (NIPCM) was readily accessible via the staff shared drive.



132. The treatment room was visibly clean, with clear responsibilities for cleaning tasks. The most recent IPC audit did not identify any issues with the environment. However, the audit process was ineffective as damage was clearly visible to the walls, flooring and to woodwork around the hand wash basin in the treatment room. This damage would not support effective cleaning and decontamination posing a potential IPC risk. It was unclear from speaking with healthcare staff if this damage had been reported to custody supervisors as responsibility for carrying out repairs to the environment, including the treatment room, lies with the custody division.

Recommendation 5

NHS Lothian should ensure that IPC audits are completed in a way that reliably identifies damage to the care environment and that repairs are carried out to allow effective cleaning and decontamination.

133. Care equipment was cleaned between patient use. Hand hygiene facilities were available, and PPE was easily accessible and appropriately stored.
134. Sharps bin disposal was compliant. Clinical waste bags were stored in a locked bin awaiting uplift. However, the bin was in a publicly accessible car park and was not secured, posing a safety and security risk. No linen was used by healthcare staff.

Recommendation 6

Police Scotland should ensure that clinical waste bags are securely stored.

135. Emergency equipment and medications were available, in date, and subject to daily checks. Systems were in place for managing urgent care and minor injuries. Staff had access to Immediate Life Support training, however compliance with the completion of training was low. We were told that this was due to limited availability of training courses. Plans were in place for staff to attend upcoming courses.

Recommendation 7

NHS Lothian should ensure staff are compliant with Immediate Life Support training.



Access to healthcare

136. Healthcare needs were identified via a vulnerability questionnaire completed by custody staff. Referrals to healthcare were made based on detainee responses, and detainees could also self-request healthcare at any time.
137. There was no national standard for healthcare assessment waiting times in custody. In the Southeast cluster, all referrals were routed through REAS's central hub, allowing monitoring of referral volumes and patterns. Referrals were electronically triaged by nurses, with waiting times influenced by detainee volume, triage outcomes, and nurse location.
138. General healthcare information was included in the 'your rights when you are at the police station' document, and was available in an easy-read format. This is considered good practice.
139. Assessments were generally conducted in the treatment room. We were told by custody staff that they preferred the door open for safety reasons. However, it was closed upon request of healthcare staff or patients to preserve dignity and confidentiality.

Recommendation 8

Police Scotland should ensure that custody staff follow Criminal Justice Service Division guidance in relation to maintaining confidentiality when patients are undergoing interventions and treatments by the healthcare team.

140. Custody and NHS staff used separate systems to record custody data, which were not compatible. Custody staff use the National Custody System (NCS) to record information relevant to detainees, whereas NHS staff use Adastrax.⁴ Relevant healthcare information and recommendations were emailed to custody staff and then manually entered onto the NCS by custody staff. Additionally, both health and police custody staff were able to provide verbal updates on the patients.

⁴ Adastrax is a highly flexible clinical patient management solution designed to support the specific and unique requirements of urgent and unscheduled care.



141. NHS staff followed appropriate procedures for documenting injuries allegedly caused by force.
142. All cells were wheelchair accessible, with one adapted for patients with mobility needs. For detainees with complex care needs, a fitness to remain in custody assessment was conducted by a nurse, followed by joint decision making with Police Scotland, this is considered to be good practice.
143. Harm reduction information and resources were available during healthcare interactions.

Medicines management

144. Governance and oversight was in place for medicines management across the southeast cluster, including St Leonards. A clinical pharmacist was available to provide support and advice.
145. Staff were able to describe the systems and processes in place for medicines management. Standard Operating Procedures (SOP) were in place to support the safe supply, storage, dispensing, and destruction of medicines. However, the SOPs described differing approaches to medicines management and at times did not reflect the practices described by healthcare staff.

Recommendation 9

NHS Lothian should review the Standard Operating Procedures related to medicines management to ensure that guidance on the safe and effective use of medicines is clearly defined. Healthcare staff must adhere to the Standard Operating Procedures in place.

146. A process was in place for ordering medications, including controlled drugs. Healthcare staff reported that NHS Lothian's Controlled Drugs Governance Team visits custody centres to safely destroy expired or unused controlled drugs. Controlled drugs registers were well maintained, and the controlled drugs license was in the process of being renewed.
147. The service had effective systems for stock rotation and expiry date checks. All drugs reviewed during the inspection were in date.



148. Robust medication reconciliation was carried out using electronic records and patient interviews. This ensured patients received their usual medications while detained, including Opiate Substitution Therapy (OST).
149. Most nurses were non-medical prescribers and prescribed all medications, including controlled drugs. Prescriptions were recorded on Aداstra. NHS Lothian had reviewed its prescribing processes and governance following previous communication from Healthcare Improvement Scotland regarding the safe prescribing and administration of medicines within the provision of police custody suites.
150. Medications (excluding OST) were dispensed into multi-compartment compliance aids to support custody staff with administration. Handwritten administration guidance and information regarding the medicines was recorded on the compliance aids. This could pose a potential risk due to the variability in labelling and a lack of warnings or guidance. Custody staff received email instructions regarding medicines administration from healthcare staff. OST was dispensed directly by nurses.

Recommendation 10

NHS Lothian should ensure that compliance aids are labelled in accordance with legal requirements, including correct administration guidance and appropriate warnings.

151. A process was in place for patients to receive nicotine replacement therapy patches if requested.



Substance use

152. Custody staff used a vulnerability questionnaire that included questions on alcohol and substance use, including dependency. Nursing staff assessed detainees showing signs of intoxication or withdrawal, using appropriate tools to monitor symptoms, conducting physical observations, and prescribe detoxification medication when needed.
153. The Scottish Government's Medication-Assisted Treatment (MAT) standards, introduced in April 2022, aim to ensure consistent, high-quality drug treatment across Scotland. NHS Lothian had developed a draft SOP for applying MAT within police custody healthcare and court liaison services.
154. The SOP acknowledged the current limitations in fully meeting MAT Standard 1, which related to initiating treatment on the same day as presentation. This standard presented particular challenges in all police custody settings due to operational constraints, such as prescribing authority, staffing availability, and the need for clinical assessment within secure environments. Despite these limitations, the SOP outlined clear referral pathways to community services and provisions for short-term OST prescribing to manage withdrawal symptoms.
155. The ability to deliver all aspects of the MAT standards had been actively discussed at both regional and national levels, with staff from the REAS contributing to Medication-Assisted Treatment Standards Implementation Network (MATSIN) groups. While national agreement on the interpretation and application of MAT standards in custody settings was still pending, the ongoing review and standardisation of implementation processes represented a positive step. These efforts support staff in delivering consistent, clinically appropriate care to individuals in custody who require medication-assisted treatment.
156. Where a person was established on OST, there were processes to obtain and maintain prescriptions where possible. Any delay in this required assessment for a substitute short term medication to prevent withdrawals and contact with the person's community services. There was a clear process within a referral pathway.
157. Naloxone was available and administered by nursing staff when on site. There were police officers on site trained to carry naloxone.



Mental health

158. All nurses used a standardised approach to health assessments, including mental health, which covered patient history, examination findings, and recommendations. Clear guidance was in place for completing assessments, with details recorded on Adastra.
159. Where concerns were identified, risk management plans were shared with custody staff, including enhanced monitoring or observation levels.
160. The on-duty healthcare team was responsible for initial mental health assessments, as outlined in the East of Scotland pathway. If same-day or emergency psychiatric assessment was required, referrals could be made to the Orchard Clinic for attendance by the duty Forensic Psychiatrist or, out-of-hours, to the Adult Psychiatry Specialist Registrar. Staff from both healthcare and custody spoke positively about strong links with the Forensic Psychiatry Service. Good access to psychiatric expertise enabled timely decision-making, supported accurate diagnosis, and ensured that individuals in custody receive appropriate and responsive mental health care, particularly in complex or high-risk situations.
161. In addition to assessing fitness for interview or court, the service supported care planning and transfer arrangements for individuals detained under the [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#).
162. Custody data showed that St Leonards was not used as a place of safety under Sections 297 and 298 of the Act in 2024, this may indicate that appropriate pathways were followed to avoid unnecessary custody for mental health assessments.
163. Arrangements were in place for young people in custody with mental health needs. Where concerns were raised or fitness to release required assessment, referrals could be made to the Child and Adolescent Mental Health Service (CAMHS) at Edinburgh Children's Hospital.
164. Detainees with learning disabilities were identified through the vulnerability questionnaire and the vulnerable persons database. Systems were in place to involve an Appropriate Adult service when required.



Pre-release pathways and referrals

165. Good processes for onward referral were evident, with a wide range of statutory and third-sector support services clearly displayed for staff.
166. We saw evidence of detainees being signposted to community services. Custody staff were knowledgeable about available support, and a range of leaflets covering mental health, substance use, wellbeing, harm reduction, peer support, and family support were accessible.
167. When a detainee was transferred to court, a Person Escort Record (PER) form was completed, including medical and medication details sourced from NCS.
168. Both nasal and injectable forms of naloxone were offered to patients on release. Although uptake was low, data indicated that it was being offered, which was a positive finding. Staff told us that the increased access to naloxone in the community was a common reason detainees frequently gave for declining it. It was positive that naloxone continued to be offered, and uptake was monitored to inform service delivery.

Local Policing

169. Inspectors spoke with officers from Local Policing who stated they considered their custody colleagues to be very helpful and accommodating.
170. It was acknowledged that there could be some tensions between operational officers and custody staff emanating from the length of time taken to process detainees. Local policing officers cited instances where detainee processing was overly long and arduous, where lengthy queues could form.
171. Officers remarked there are rarely sufficient custody staff to run three charge bars and the impact on operational policing can be substantial, particularly at peak times.



172. Officers acknowledged the existing challenges with staffing resilience at the centre, highlighting that this undoubtedly had a negative impact on custody capability and staff morale.

173. Custody supervisors stated that local policing officers often struggle with the interpretation of the Criminal Justice Act 2016, and will regularly challenge custody decisions. The CJSD recognises that a training course on the legislative provisions of the Act will be required to reduce or eliminate misinterpretation and provide a wider understanding of implications for custody. Plans are being developed by CJSD to introduce related training.



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

Tel: 0131 244 5614

Email: hmic@gov.scot

Web: www.hmics.scot

About His Majesty's Inspectorate of Constabulary in Scotland

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

© Crown copyright 2026

978-1-910165-95-9

HMICS/2026/04