HM Inspectorate of Constabulary in Scotland
Improving Policing across Scotland

Thursday, 28 March, 2024

PRESS RELEASE

Police Custody in Fife Inspected

The quality of record keeping, risk assessment and care planning for those being held within Police Scotland's custody centres in Fife was inconsistent and needed to be improved, stated a report published today Thursday, 28th March, 2024.

Concerns had been expressed about omissions in relation to the matching of risk assessments to care plans, documenting of searches of detainees, cell visits, provision of food and drink, washing, contact with named persons and medicines.

HM Chief Inspector of Constabulary in Scotland, Mr Craig Naylor, said: "It was unclear if these gaps reflected poor and inconsistent practices or poor recording. However, we could not be confident these activities were taking place consistently."

As part of a joint inspection of police custody facilities at Dunfermline and Kirkcaldy, a sample of records from the Police Scotland National Custody System (NCS) were examined.

The inspection was carried out jointly by HMICS and Healthcare Improvement Scotland (HIS) and provided an analysis of the quality of custody centre operations as well as the provision of healthcare services. HMICS Custody Inspection Report - Fife contains 15 recommendations for Police Scotland and the NHS.

Mr Naylor added: “We identified issues in the records regarding the discrepancy between some risk assessments undertaken and the corresponding care plans in place. There were instances where the care plan appeared to be set at a lower level than the risk assessment would suggest as appropriate. In 47% of cases within our sample where the risk assessment was recorded as high, the care plan was set to level 1 or standard observations. Rationales to support those decisions were consistently absent from custody records.

“Given that those in custody described being respected by the staff and provided with everything they needed, the findings from our review of records may reflect poor recording rather than poor practice. But it was difficult to draw conclusions in the absence of comprehensive records.”

Staff had been provided with electronic tablets to carry out contemporaneous recording of observations but were not using them at the time of the inspection and we found no evidence that supervisors were promoting the use of these devices to ensure the accurate and timely recording of cell visits.

The report also identified issues with the physical layout of the two centres and a general lack of facilities. Some of the sleeping plinths in Dunfermline presented a potential ligature hazard, the unconventional layout of the charge bar at Dunfermline led to inefficient working, and the areas set aside for CCTV observation of detainees were not fit for purpose due to being in busy offices where the operator could become distracted.

There were adequate staffing levels at both centres and detainees were complimentary about the custody staff and their surroundings which were clean and reasonably well maintained despite being within older properties. However there were no showers in either location and the only sinks were in central corridors, which could limit privacy. Kitchens were tidy and hygienic with a variety of appropriate food stuffs available.

The booking in process followed at both sites was considered to be good practice by inspectors although there was an element of risk while the detainee remained in the vehicle used for transport to the centre with one officer as the other went inside to brief the sergeant.

Inspectors commended the appointment of a pharmacist to oversee the management of medicines in custody centres across South East Scotland, nurses offering harm reduction advice and referrals to a support project, known as Navigators. Take home nasal Naloxone kits were also available for detainees once released.

Three months following the inspection of the premises, a death was recorded at the custody centre in Kirkcaldy. The incident is being investigated, as required, by the Police Investigations and Review Commissioner and a mandatory fatal accident inquiry will be held in due course. It would not be appropriate for HMICS to comment on the circumstances while investigations are being carried out.

Ends

Notes

This inspection, which was unannounced and took place in October 2023, involved the analysis of a sample of custody records relating to people detained at the custody centres, interviews with detainees and staff during the inspection and an assessment of the premises, including the quality of the cells, key processes and procedures.

The Dunfermline and Kirkcaldy police custody centres were located within the local area police stations. The overall cell capacity at Dunfermline was 18 cells while Kirkcaldy had 15 cells. There was also an ancillary custody centre, based in Levenmouth, which was not routinely staffed and was outwith the scope of this inspection.

Healthcare was provided peripatetically and delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service which was hosted and managed by NHS Lothian.

Police custody has been the subject of considerable scrutiny by HMICS since the service was established in 2013. Significant progress has been made by Police Scotland in implementing previous recommendations and it is actively working to address those which remain outstanding.

This was the fourth inspection in a joint custody inspection programme that has been developed by HMICS in partnership with HIS. Common themes that had featured in recommendations or in areas for improvement in previous reports were referenced where applicable. Recommendations which will be equally applicable to other custody centres across Scotland were also referenced.

The inspection contributed to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment of Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by 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.

Ends notes

NOTES TO EDITORS

The HMICS Fife Custody Inspection Report will be available for download on the HMICS website www.hmics.scot from 0001hrs, Thursday, 28 March, 2024.

For any media enquiries please contact:

Jenny Morrison
HMICS Communications
hmic@gov.scot
Twitter: @hmics

Ends