HMICS

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND

Inspection of custody centres at Aikenhead Road and London Road, Glasgow

July 2016

Improving Policing Across Scotland

npm national preventive mechanism

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HM Inspector 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).[1]

We have a statutory duty to ensure that the Chief Constable and the SPA meet their obligations in terms of best value and continuous improvement. If necessary, we can be directed by Scottish Ministers to look into anything relating to the SPA or Police Scotland as they consider appropriate. We also have an established role in providing professional advice and guidance on policing in Scotland.

- Our powers allow us to do anything we consider necessary or expedient for the purposes of, or in connection with, the carrying out of our functions.
- The SPA and the Chief Constable must provide us with such assistance and co-operation as we may require to carry out our functions.
- When we publish a report, the SPA and the Chief Constable must also consider what we have found and take such measures, if any, as they think fit.
- Where we make recommendations, we will follow them up and report publicly on progress.
- We will identify good practice that can be applied across Scotland.
- We work with other inspectorates and agencies across the public sector and co-ordinate our activities to reduce the burden of inspection and avoid unnecessary duplication.
- We aim to add value and strengthen public confidence in Scottish policing and will do this through independent scrutiny and objective, evidence-led reporting about what we find.

Our approach is to support Police Scotland and the SPA to deliver services that are high quality, continually improving, effective and responsive to local needs.[2]

We are a member of the United Kingdom's National Preventive Mechanism, a group of organisations which independently monitor places of detention, including police custody, under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.[3]

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.

[1] Chapter 11, Police and Fire Reform (Scotland) Act 2012.
[2] HMICS, *Corporate Strategy 2014-17* (2014).
[3] For more information, see http://www.hmics.org/what-we-do/national-preventive-mechanism-npm.

Our inspection

The aim of this inspection was **to assess the treatment of and conditions for those detained in police custody centres located at Aikenhead Road and London Road in Glasgow**.

Our inspections of police custody usually take the form of a thematic inspection, or take place as part of our Local Policing+ Inspection Programme under which we inspect all custody centres located in a particular local policing division. This inspection was in addition to our regular programme and took place at the request of Police Scotland. While the principal aim of the inspection was to provide assurance about the delivery of custody at both custody centres, the secondary aim was to assist Police Scotland's Criminal Justice Services Division in developing its own, internal audit processes. Our inspections of Aikenhead Road and London Road followed our usual format, except that when we reviewed a sample of custody records, we did so jointly with a representative of the Criminal Justice Services Division. This allowed us to share and discuss our methodology with the division.

The inspection is part of an on-going programme of custody inspections which contribute to the United Kingdom's response to its international obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or 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 the treatment of and conditions for detainees. HMICS is one of several bodies making up the NPM in the UK.

Our inspections are based on an inspection framework which ensures a consistent and objective approach to our work. The framework consists of six themes:

- Outcomes
- Leadership and governance
- Planning and process
- People
- Resources
- Partnerships

Each theme is supplemented by a range of indicators setting out what we expect to find during our inspection. In relation to custody, the 'outcomes' theme features additional indicators specific to custody. These focus on the treatment of and conditions for detainees. Our custody inspections predominantly focus on these custody-specific outcomes, but we also comment on the other themes from our framework where appropriate.

Our inspections of both Aikenhead Road and London Road custody centres were unannounced. During our visits, we assessed the physical environment, interviewed detainees, custody staff and other professionals working in the custody centre (such as nurses), observed key processes and reviewed a sample of custody records. Unannounced visits can limit what we see during our inspections of custody as we may only observe what we find at the time of our visit.

Our inspection of custody centres at Aikenhead Road and London Road follows our thematic inspection of police custody arrangements (published in 2014) as well as our regular inspections of police custody which take place as part of our Local Policing+ Inspection Programme.[4] To date, we have inspected custody centres in Aberdeen City, Edinburgh and Dumfries and Galloway Divisions. In response to recommendations and improvement actions arising from these inspections, Police Scotland has developed an implementation plan. Where relevant, we have taken the opportunity to comment on progress made against our previous recommendations in this report. Where we find sufficient evidence, we will discharge those recommendations. Some recommendations and improvement actions made in respect of a particular custody centre will be relevant to some or all other custody centres in Scotland. Police Scotland should ensure that learning from each inspection, including from any good practice highlighted, is considered across the custody estate.

HMICS wishes to thank the officers and staff of the Criminal Justice Services Division for their assistance during our visits to the two custody centres. The inspections were carried out by Laura Paton and Tina Yule, Lead Inspectors at HMICS.

Derek Penman QPM
HM Inspector of Constabulary in Scotland
July 2016

[4] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014); HMICS, *Local Policing+ Inspection Programme: Inspection of custody centre located in Aberdeen City Division* (2015); HMICS, *Local Policing+ Inspection Programme: Inspection of Edinburgh Division* (2015) (see Part 2 – Inspection of custody centres located in Edinburgh Division); and HMICS, *Local Policing+ Inspection Programme: Inspection of Dumfries and Galloway Division* (2016) (see Part 2 – Inspection of custody centres located in Dumfries and Galloway Division).

Key findings

- Staff working at Aikenhead Road and London Road custody centres were professional and respectful, and the detainees we spoke to were generally satisfied with how they were treated.
- Following our visit to Aikenhead Road, we provided feedback to Police Scotland. Much of this feedback was acted upon in the subsequent weeks and, as a result, we found fewer causes for concern at London Road.
- The cells at Aikenhead Road in particular were dirty and were in need of an urgent deep clean.
- It was not always clear why a detainee had been assessed as low or high risk, nor was the rationale for the subsequent care plans always apparent. While there was still scope for improvement, the quality and recording of risk assessments was better at London Road.
- Where detainees were assessed as high risk, the default care plan at both centres appeared to be constant observations via CCTV and 60-minute rousing. There was little or no use of 15 or 30-minute checks, contrary to practice in other custody centres we have visited. This was a resource intensive approach to care planning.
- For very high risk detainees, it is questionable whether constant observations via CCTV coupled with only 60-minute rousing is sufficient to safeguard their health and wellbeing.
- Items such as a detainee's glasses or bra should only be removed from the detainee where indicated by the risk assessment. Risk assessments should be reviewed and such items should be returned at the earliest opportunity.
- Some Person Escort Records had not been completed with all relevant risk factors.
- At London Road, good use was made of pre-release risk assessments for those detained for sexual offences.
- Male and female detainees were held on mixed cell corridors and we had some concern about constant observations being carried out by staff of the opposite gender from the detainee.
- There were generally good handovers between sergeants working in custody, with good briefing of incoming teams on the history and needs of individual detainees at London Road in particular.

Recommendations

Recommendation 1

Police Scotland should explore why 15 and 30-minute observations are not being used in some custody centres and provide further guidance and training to staff where necessary.

Recommendation 2

A detainee's gender and dignity should be key considerations when allocating a member of staff to carry out constant observations. There should be a presumption, unless a risk assessment dictates otherwise, that constant observations should be carried out by someone of the same gender as the detainee.

Recommendation 3

Wherever possible, male and female detainees should be held in separate areas within the cell accommodation.

Context

1. Custody is delivered throughout Scotland by the Criminal Justice Services Division. This division is one of several national divisions which sit alongside and support the 13 local policing divisions. A single, national division was established to promote consistency in working practices across custody centres in Scotland. The division is led by a Chief Superintendent, who reports to an Assistant Chief Constable and, in turn, to the Deputy Chief Constable with responsibility for local policing. Custody is delivered in accordance with the custody standard operating procedure (the 'custody policy').[5]

2. Custody centres in Scotland are organised into clusters, each led by an Inspector. The custody centres at Aikenhead Road and London Road in Glasgow are in different clusters, but both are primary centres meaning they are permanently staffed and open to receiving detainees at all times. There are two other custody centres located in Greater Glasgow Division (at Govan and Stewart Street).

Custody centre	Type	Number of cells	Throughput in 2015[6]
Aikenhead Road	Primary	58	8,324
London Road	Primary	37	5,216

Deaths in custody

3. The Police Investigations and Review Commissioner (PIRC) is an independent statutory body whose role includes investigating the most serious incidents involving the police, including deaths in police custody.

4. In November 2013, there was a death in custody at London Road. Ian Loudon, aged 39, died in his cell at the custody centre. The circumstances of the death were investigated by PIRC and a report submitted to the Crown Office and Procurator Fiscal Service. A Fatal Accident Inquiry (FAI) into the death was held and a report was published in December 2015. One of the purposes of an FAI is for the Sheriff to determine whether there were any reasonable precautions whereby the death might have been avoided. In this case, the Sheriff concluded there were three such precautions.

5. The first was that the police should have taken Mr Loudon to hospital immediately upon his arrest. The arresting officers had initially sought to do so, but were instead told by the custody sergeant at London Road to bring Mr Loudon to the custody centre as the police casualty surgeon was present. The second precaution was that the police casualty surgeon should have carried out an adequate and appropriate examination of Mr Loudon and should have sent him to hospital. The Sheriff found the examination by the police casualty surgeon took less than two minutes and expected checks were not carried out. The third precaution was that the Police Custody Security Officers (PCSOs) who placed Mr Loudon in the recovery position while in his cell should have reported his condition and their actions to the custody sergeant. The sergeant should then have personally checked Mr Loudon and sent him to hospital.

6. The circumstances of the death of Mr Loudon, as set out by the Sheriff, raise issues regarding several aspects of detainee care in custody including risk assessment and care planning (as well as reviews of risk assessment and care plans), constant observation of detainees via CCTV, rousing of detainees, recording of visits to detainees, handovers between teams and medical assessment.

[5] Police Scotland, *Care and welfare of persons in police custody – standard operating procedure* (2015).
[6] In 2015, changes to the custody operating model (including closures for building works) caused fluctuating throughput which is not indicative of previous or future throughput. This was particularly so for the custody centre at London Road.

7. In January 2013, Gerard Tierney, aged 43, died in hospital after being taken there from his cell at Aikenhead Road custody centre. While Mr Tierney's death took place two months prior to the creation of Police Scotland, the FAI into his death was not published until December 2015. In his report, the Sheriff cited medical evidence that no action taken by custody staff could have prevented Mr Tierney's death. Although Mr Tierney's death could not have been prevented, the circumstances described by the Sheriff raise some issues similar to those raised by the death of Mr Loudon, including risk assessment and handovers between teams.

8. The issues raised by the two FAIs have been taken into consideration during our inspections of the custody centres at Aikenhead Road and London Road.

Outcomes

Treatment and conditions

9. The custody centres at Aikenhead Road and London Road are both large, busy facilities. Each centre is managed by a sergeant and staffed by PCSOs. When PCSOs are on leave or otherwise absent, cover is provided by police officers from the local policing division. We visited Aikenhead Road in April 2016 and London Road in May 2016. Following the first visit, we gave immediate feedback to Police Scotland about what we found. This provided the division with the opportunity to take immediate action to address our findings not only at Aikenhead Road, but to also put in place any remedial measures in advance of our visit to London Road. This may explain, in part, why we identified fewer causes for concern during our visit to London Road. We commend the division for taking such prompt action and are reassured that it will continue to improve.

Arrival in and release from custody

10. At both Aikenhead Road and London Road custody centres, the arrival and departure of detainees is generally managed safely and securely and can be monitored by CCTV. While the vehicle docking area at Aikenhead Road is a good size and ostensibly secure, we noted a few items lying around in the docking area which could be used as a weapon or to aid escape. These items have since been removed. We also noted that the door leading from the docking area to the custody centre was often left open. Similarly, the main route from the custody centre to the police station was often left insecure. We have previously commented on the need to maintain the security of the custody environment.[7] Security was generally better at London Road, although there is no separate docking area for vehicles transporting detainees. The vehicles are loaded and unloaded in the station's large, secure car park. Those escorting detainees appeared aware of the need to maintain control of detainees on arrival at and departure from the centre.

11. On arrival, detainees remain in a holding area pending checks being carried out to identify if there are any warning markers that may indicate, for example, a history of violence or self-harm. The holding area at Aikenhead Road is particularly well-designed and positioned. The area is glass-fronted and is located across from the booking in desks. This allows custody staff to easily monitor the number of detainees waiting to be processed and to assess whether particular detainees should be prioritised (for example, due to a vulnerability such as age, or because they are being disruptive in the holding area).

12. Once checks are complete, detainees are booked in by custody staff. This process is carried out or overseen by the custody sergeant. There are three booking in desks at Aikenhead Road which, if used simultaneously, create a slightly chaotic and noisy atmosphere which compromises privacy and is not conducive to effective risk assessment. Generally, custody staff prefer to use one desk at a time although, during a particularly busy period, we observed all three being used at once. At London Road, there are two booking in desks separated by a narrow privacy screen. The centre was not busy at the time of our visit and we only saw one desk being used.

13. During our visit to London Road, we observed one detainee being released. This detainee had been interviewed by the police regarding allegations that he had committed a sexual offence and, in these circumstances, we were pleased to note that officers had carried out a pre-release risk assessment. We observed discussions between arresting officers and custody staff regarding the need for such assessments where sexual

[7] HMICS, *Thematic inspection of police custody arrangements in Scotland* (2014), paragraph 43 and Recommendation 4.

offences had been alleged, and we found additional evidence of their use at London Road when we reviewed a sample of custody records.

14. Each day, a private contractor (G4S) attends the custody centres to escort those detainees due at court. While we did not observe the handover process on our visits to Aikenhead Road and London Road, we did review several Person Escort Records (PERs) at each centre. The PER is completed by custody staff and given to G4S as a means of sharing known risks that a detainee poses to themselves or others. While the majority of PERs we reviewed were satisfactory, there were a few that had key risk factors missing. We have previously recommended that Police Scotland ensure that staff complete the PER with all relevant risk factors and that reviewing PERs should form part of the division's quality assurance process.[8] In early 2016, Police Scotland completed an audit of more than 750 PERs across all primary custody centres in Scotland with the majority being found to be of a good standard. Following the audit, a memorandum was issued to all staff regarding accurate completion of PERs which Police Scotland expects will result in an improvement in quality.

Risk assessment

15. During the booking in process, a risk assessment is carried out for every individual who comes into police custody. Effective risk assessment is vital for the appropriate care and management of detainees. A key element of the assessment is the vulnerability questionnaire, when custody staff ask the detainee questions relating to drug or alcohol use, medical history etc. During our inspection, we observed vulnerability questionnaires being delivered to several detainees and we reviewed additional risk assessments via a sample of custody records.

16. We saw some staff asking good follow-up questions to those set out in the vulnerability questionnaire (although the useful supplementary information gathered was not always recorded), and we also found evidence that staff were routinely searching the Criminal Justice Services Division's adverse incident database for intelligence that may inform a detainee's care plan. We noted that some custody staff would benefit from asking questions more slowly and ensuring that detainees have completed their answer before moving on to the next question.

17. The initial risk assessment process concludes with custody staff determining a care plan for detainees. This involves determining whether the individual is high or low risk, and what level of observation they should receive. Under the current custody policy, observations can either be constant, or at 15, 30 or 60-minute intervals. All detainees are subject to at least 60-minute checks.

18. In previous inspections, we have noted that it is not always clear to us from the information recorded on the custody record why a detainee has been assessed as high or low risk, nor was it clear why a particular level of observations was chosen.[9] This was also true of the custody records we reviewed at Aikenhead Road. In one record we reviewed, the observation level had not even been specified and so we assumed it was set at 60 minutes. We also saw little evidence in the custody records we examined of risk assessments being reviewed and care plans being updated. Following our review of custody records at Aikenhead Road, which was conducted alongside a Chief Inspector from the Criminal Justice Services Division, the division encouraged its staff to improve the quality of information included on the custody record, particularly the rationale for the risk assessment. We found evidence of improvement when we reviewed records at London Road the following month, although there were still cases where we were not sure the care plan was correct, based on the information recorded.

[8] See, for example, HMICS, *Inspection of Edinburgh Division* (2015), Recommendation 5.
[9] HMICS, *Inspection of custody centre located in Aberdeen City Division* (2015) at paragraphs 16 and 17 and Improvement Action 3; HMICS, *Inspection of Edinburgh Division* (2015) at paragraph 245.

19. At both custody centres, there appeared to be a reluctance to use either 15 or 30-minute observations. Instead there appeared to be an 'all or nothing' approach: detainees were either low risk and could be observed at the minimum 60-minute level; or detainees were high risk and required constant observation. We found examples of cases where constant observation had been used unnecessarily, and we found cases where detainees with risk factors were placed on 60-minute observations when 15 or 30 minutes would have been more appropriate (which was particularly concerning as we saw a few examples of visits being conducted at 70 minute intervals and one of what we considered to be a high risk detainee at 96 minutes). Custody staff did not see any value in using the interim level of observations, despite these being widely used at other custody centres across Scotland.

Recommendation 1

Police Scotland should explore why 15 and 30-minute observations are not being used in some custody centres and provide further guidance and training to staff where necessary.

20. While the custody record system used at both centres does not hinder the recording of risk assessment rationales and care plans, neither does it facilitate effective recording in the same way as the system used in Dumfries and Galloway. We are therefore pleased to note that Police Scotland is considering rolling out the system used in Dumfries and Galloway across Scotland. If a national custody IT system was in place which allowed for effective data analysis, inconsistencies in practice such as the reluctance to use 15 and 30-minute observations at Aikenhead Road and London Road custody centres could be more easily identified and their causes explored.

21. The use of constant observations has significant resource implications. At both centres, constant observations were carried out via CCTV by a police officer from the local policing division. The police officer is removed from his or her usual duties for this purpose. Custody staff told us that they will not usually carry out constant observations themselves, except to provide the police officers with short breaks. We observed this to be the case even when the custody centre was quiet and some PCSOs had little to do. While we appreciate that quiet custody centres can become busy very suddenly, custody sergeants should give more thought to whether abstracting a police officer from their regular duties is really required, taking into account factors such as the number of other people in custody and the number of PCSOs available.

22. Items such as glasses and bras may be removed from detainees where indicated by the risk assessment. The fact such items are removed, and the reason why, should be recorded. Risk assessments should be reviewed and such items should be returned at the earliest opportunity. During our visits, we observed that such items were removed in some cases, even where the risk assessment did not appear to indicate it was necessary and where no reason for removal was recorded. Where glasses are removed, detainees should be asked whether they need assistance with reading their Letter of Rights, or any other aspect of their detention. Where bras are removed, they should not be left hanging outside the detainee's cell but should be stored alongside the rest of the detainee's property.

Custody environment

23. The custody centre at Aikenhead Road has 58 cells while the centre at London Road has 37 cells. All cells were of a good size. While all the cells at London Road had natural light, they were nonetheless quite dim, even with the lights switched on. Cells at both centres had a toilet (flushed from outside the cell by a member of staff upon request), a call button and a bench. There was one dry cell with no toilet at Aikenhead Road. Mattresses, pillows and blankets were available, but the quality of the majority of blankets at Aikenhead Road was very poor and they should be replaced. The benches in all cells

at both centres were low and therefore unsuitable for detainees with mobility problems. Although there was an accessible shower at Aikenhead Road, neither centre had any accessible cells (with, for example, a call button placed within reach of a high bench), and staff told us that they would do their best to accommodate a disabled detainee or would make arrangements for them to be transferred to another custody centre with more suitable accommodation.

24. The cell area and the cells themselves at Aikenhead Road were dirty. The cleaning arrangements were clearly not sufficient and walls and ceilings were stained with food and/or bodily fluids. Many cells were covered in graffiti and required repainting. Some floors were also in a poor state. Staff at Aikenhead Road told us that during busier times, cells could be reused without being cleaned between detainees. Staff at London Road told us that cells would not be reused, and would simply be closed until cleaning staff attended. In other centres we have visited, custody staff will clean cells between uses if cleaning staff are not available. Custody staff at Aikenhead Road and London Road feel unable to do any cleaning themselves as they have not been trained, are concerned about cross-contamination and are unclear about the usual cleaning practices used by the contracted cleaning company.

25. Immediately after our visit, we recommended to Police Scotland that Aikenhead Road receive an urgent deep clean and that, thereafter, improved cleaning arrangements be put in place. We have been assured by Police Scotland that Aikenhead Road was cleaned in the weeks following our visit and that on-going cleaning arrangements are under review. We found the cells at London Road to be cleaner than Aikenhead Road, but felt they too would benefit from improved cleaning arrangements.

26. Both centres have washing areas which include showers and sinks. There were ligature points in both washing areas although we were told that detainees would never be there unaccompanied. The screening of the showers at Aikenhead Road was very poor and afforded little privacy, particularly as the showers were on a main corridor and were covered by CCTV. The showers were appropriately screened at London Road and were on a separate corridor, however staff told us that take up of showers there was poor.

27. There were two interview rooms at London Road which did not appear to meet demand. We were told that officers often had to wait to use the interview rooms. New solicitor access rooms had been created, but the centre had lost two observation cells as a result. There also appeared to be a lack of storage space at London Road, as well as a lack of some supplies essential to the care of detainees (see paragraph 38).

Detainee care

28. We found custody staff working at Aikenhead Road and London Road to be professional and respectful, and the detainees we spoke to were generally satisfied with how they were treated. We observed an effective handover process between sergeants working in custody at both centres, and, at London Road in particular, good briefing of incoming teams on the history and needs of individual detainees.

29. Each interaction with a detainee and the detainee's movements around the custody centre (e.g. to interview or to see the nurse) should be recorded on a 'cell sheet'. This is a paper system, with cell sheets placed outside each cell and updated by staff after every interaction. We reviewed cell sheet entries alongside detainees' electronic custody record. At Aikenhead Road, we found entries on cell sheets to be cursory and noted that not all interactions or movements were logged. Custody staff were advised of the need to improve their recording and we noticed an improvement in the quality of entries on cell sheets when we visited London Road. There remains scope for further improvement however and the quality and accuracy of cell sheets will be considered by the Criminal Justice Services Division as part of its internal audit arrangements.

30. As in previous inspections, we noted that detainees are not routinely told about the call button in their cells or when to use it. This is particularly important for those people staying in custody for the first time. Detainees are also not always made aware of their entitlements while in custody. For example, at Aikenhead Road, we spoke to one Muslim detainee who was not aware that he could ask to wash before praying, that he could be taken to a different cell to pray that had no toilet and in which the direction of Mecca was marked, and that he could have a prayer mat and a Qur'an. On one custody record we examined, we noted that another Muslim detainee had asked if he could pray and, although he stayed in custody for another three nights, there was no further mention of this or how staff had responded. All custody centres we have visited have some specialist provision for Muslim detainees as well as detainees of other faiths and they should be made aware that their religious needs can be met while in custody.

31. At both custody centres, staff of the opposite gender were routinely being used to carry out constant observations of high risk detainees via CCTV. This may not always be appropriate, for example, when the detainee is in a state of undress (some staff we spoke to thought it was never appropriate). We also noted that both centres were holding female and male detainees on mixed corridors. In the past, one corridor would have been designated as the 'female' corridor and all women would have been placed there. While it is not possible to always maintain this gender separation when the centre is operating close to capacity (because the 'male' corridor becomes full more quickly due to the preponderance of male detainees), separation should be sought wherever possible. This has previously been the subject of an improvement action directed to Police Scotland[10] and we are disappointed that not only has it not been implemented, but the practice of mixing male and female detainees has become even more widespread.

32. This practice of mixing male and female detainees within custody centres appears to have come about following a change in approach to gender-related care outlined in a memorandum to custody staff dated 15 September 2015. This change was driven by a desire to no longer have gender-specific custody centres in the West, thereby making the most effective use of the custody estate and custody staff.

33. While it may be acceptable for staff to perform some caring duties in relation to detainees of the opposite gender in some circumstances (e.g. a cell check, where the cell door is knocked first to check the detainee is appropriately dressed and not using the toilet), it is important that arrangements for the care and management of detainees preserve the dignity of both detainees and staff and take account of the vulnerabilities of individual detainees. The memorandum made no change to the custody policy, the latest version of which (dated 28 October 2015) continues to state that, 'Male and female custodies are to be kept in separate cells and, wherever possible, in separate areas within the cell accommodation'. This is in keeping with international human rights standards,[11] and reflects research evidence[12] that suggests women in the criminal justice system are more likely to have been the victim of domestic and sexual abuse and, therefore, may be particularly intimidated by being placed on the same corridor as male detainees. Additionally, in some custody centres, including at London Road, some door peepholes are large and uncovered, meaning detainees would be able to observe other detainees being moved around the cell area. Changes to practice and policy such as the mixing of male and female detainees within custody centres and other aspects of gender-related care should be subject to equality and human rights impact assessments, and where

[10] HMICS, *Inspection of custody centre located in Aberdeen City Division* (2015), Improvement Action 5.
[11] For example, the Rule 8(a) of the UN Standard Minimum Rules for the Treatment of Prisoners refers to the separation of men and women detained in the same institution and applies to all categories of prisoner, including those who are untried.
[12] In its report on *Improving the police response to domestic abuse* (2014), HM Inspectorate of Constabulary in England and Wales cited evidence that as many as half of the women who have passed through the criminal justice system and then entered prison have experienced domestic violence, and up to a third have been victims of sexual abuse.

issues arise, the advice of expert organisations, such as the Scottish Human Rights Commission, should be sought.

Recommendation 2

A detainee's gender and dignity should be key considerations when allocating a member of staff to carry out constant observations. There should be a presumption, unless a risk assessment dictates otherwise, that constant observations should be carried out by someone of the same gender as the detainee.

Recommendation 3

Wherever possible, male and female detainees should be held in separate areas within the cell accommodation.

34. In both centres, constant observations were carried out via CCTV. Screens were capable of showing four cells at once, meaning the picture of each cell was quite small. We are unsure whether staff are capable of sufficiently monitoring four cells simultaneously where detainees are in genuine need of constant observation. It is also worth noting that in England and Wales, the Authorised Professional Practice for detention and custody requires that constant observations by CCTV be accompanied by 30-minute rousing, not 60-minutes as was usually the case in the records we reviewed at both Aikenhead Road and London Road. For some detainees who are sufficiently high risk as to require constant observations, monitoring by CCTV and 60-minute rousing will not be sufficient. It will not, for example, allow for changes in breathing or consciousness to be easily monitored. Constant monitoring accompanied by more frequent visits would be a more appropriate care plan for some detainees.

35. In light of our concerns about various aspects of the use of constant observations, we welcome plans by the Criminal Justice Services Division to review its policy on the matter and the consideration being given to adopting a staged approach to care planning and observations similar to that in use in England and Wales.

36. At Aikenhead Road, we found magazines in both rooms in which constant observations by CCTV are carried out. This is not appropriate. When conducting observations, officers' attention should be focused on the detainees and they should be reminded of this upon commencing their observation. They should not be reading, nor using their personal mobile phone. There appears to be no guidance on how long officers should carry out constant observations. To maintain focus, it is suggested that officers do not do this for an entire shift.

37. CCTV images of cells are pixelated so that the toilet area is not shown, but in each custody centre there was one cell where the pixelation required slight adjustment to adequately preserve the detainee's dignity. This should be rectified.

38. Staff at both centres told us they can run low on supplies essential to the care of detainees and sometimes have to visit supermarkets to purchase items. Both centres appeared insufficiently stocked on items such as underwear and sanitary towels. We were told that the division has sought to put in place a more effective approach to stock management following a review which showed excessive stock levels in some areas. While effective stock management is desirable, the new approach appears to be having a negative impact in some areas. We encountered a similar issue when we inspected custody centres in Edinburgh in 2015. The Criminal Justice Services Division should continue to monitor its process for ordering and maintaining supplies and should ensure there is a mechanism by which problems can be raised by staff.

Individual rights

39. Appropriate grounds for detention existed for detainees in custody at the time of our inspection, and the detainees were held for no longer than was required. In one custody record we reviewed relating to a 15-year-old, we noted that staff sought to process the child as quickly as possible and limit his time in custody. All detainees were provided with a Letter of Rights, a short booklet setting out their rights. Aside from young people attending the custody centre with their care worker, appropriate adults were not needed for any detainees during our inspection. Staff told us that the appropriate adult provision can be variable and there can be delays in attendance. This is an issue we will continue to monitor during our inspections of custody.

40. During our inspection of London Road, we noted that some detainees had been brought some distance to the custody centre, bypassing other custody centres that were closer to the point of detention. We were informed by custody staff that this was not uncommon. The reason given was that several divisional investigation units (such as the Divisional Rape Investigation Unit) are based at London Road Police Office. The officers tend to bring suspects to the officers' home station for interview. While this may be convenient for the officers, consideration should be given to the impact this may have on detainees. Some solicitors will be reluctant to travel great distances to attend an interview for their client and even if they do, this may cause delays. Some local authorities may be reluctant to provide an appropriate adult for detainees not from their local area; while a home local authority may be reluctant to send an appropriate adult a great distance (and, as with solicitors, there would be a delay in attendance in any case). Additionally, family or friends of detainees kept in custody far from home may not be able to drop off fresh clothes for a court appearance. Investigating officers should be alert to these issues, particularly for vulnerable detainees, and consider alternatives where needed, such as using a local custody centre or, where possible, making arrangements in advance for solicitors or appropriate adults to attend.

Health care

41. The custody centres at Aikenhead Road and London Road benefit from an on-call nurse-led health care service. The nurses are based at the custody centre at Govan but will attend at other centres when needed. Doctors are also available to attend when required. When reviewing custody records, we noted that there can be delays in putting the outcome of medical assessments and advice for detainees' care plans on the custody system. This occurs when health care staff have several detainees to assess and only pass their notes to the custody sergeant once they have seen all detainees. We were told that where advice was urgent and may have implications for the immediate or short-term care of detainees, that health care staff would notify custody staff immediately. It is essential that this is done, and that custody staff update records immediately, so that all staff working in the centre are aware of important changes to detainees' health status and any amendments to detainees' care plans.

42. Some custody staff we spoke to were concerned at the length of time taken by health care staff to carry out medical assessments. This was due to the fact that a member of custody staff must accompany the detainee to and from the medical room and wait outside during the assessment, meaning they are unable to carry out any other duties. While we appreciate this can be time consuming, particularly if there are many detainees waiting to see the nurse or doctor, it is important that medical assessments are carried out to the full extent required. In the FAI into the death of Ian Loudon, the Sheriff was critical of the cursory assessment to which he was subject. At Aikenhead Road, we were told that two members of staff were required to escort detainees for medical assessments. We felt one member of staff would be sufficient in many cases, based upon an assessment of risk.

People and resources

43. Compared to other custody centres we have visited, there were fewer custody staff vacancies which meant local resources were easier to manage and there would be less need to rely on local policing officers providing support to the delivery of custody were it not for both centres' frequent use of constant observations and their reliance on local policing officers to conduct such observations. Despite there being fewer vacancies, PCSOs still told us they experienced difficulties taking annual leave, similar to PCSOs working at custody centres in Dumfries and Galloway and Edinburgh. The Criminal Justice Services Division should ensure there is a mechanism by which staff can easily raise issues, such as difficulties in taking leave, and ensure those issues are addressed

44. Custody staff at both centres noted that the Officer Safety Training which is delivered to all police officers and custody staff is not as relevant to them and they could benefit from safety training which is more focused on the custody environment. Training delivered by the Scottish Prison Service (SPS) to prison staff may be more appropriate for police custody staff and Police Scotland may wish to liaise with SPS regarding such training provision.

HM INSPECTORATE OF
CONSTABULARY IN SCOTLAND

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

Tel: 0131 244 5614

Email: hmic@gov.scot

Web: www.hmics.org

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