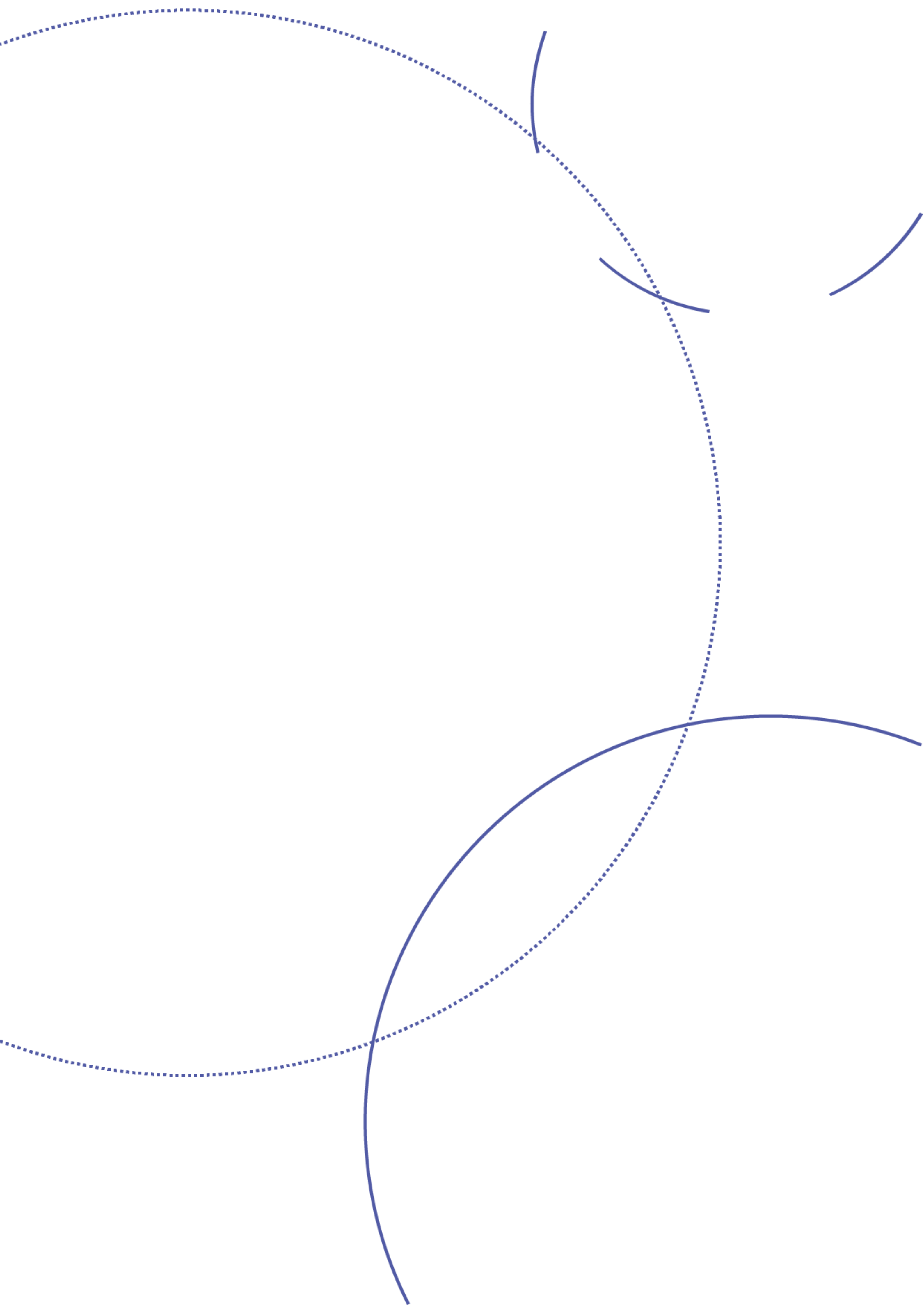
HMICS Custody Inspection Report - Tayside

July 2023

HM INSPECTORATE OF CONSTABULARY IN SCOTLAND

Improving Policing Across Scotland



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).[1]

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 look into 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.

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] Police and Fire Reform (Scotland) Act 2012, Chapter 11.

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Our Inspection

During the course of 2022, HM Inspectorate of Constabulary in Scotland (HMICS) and Healthcare Improvement Scotland (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.[2] The learning from the review has been used to support HIS to develop an interim framework to inspect healthcare services within police custody,[3] and for the scrutiny partners to devise a methodology for the joint inspection of police custody centres.

As part of this overarching review it was agreed that we would undertake two joint custody inspections in order to continue to develop inspection methodology and to complete our inspection framework. We selected the primary custody centres in Lanarkshire for our initial inspection, a report on which was published in April 2023.[4] The second of these, and the subject of this report, was undertaken in Tayside with a focus on the primary custody centre in Dundee.

The inspection was carried out jointly by HMICS and HIS, the aim of which was to assess the treatment of, and conditions for, individuals detained at the custody centre. We will outline within this report, information relevant to the efficiency and effectiveness of custody centre operations.

Responsibility for the provision of healthcare services is a function of the chief officer of Angus Health and Social Care Partnership (HSCP) as the lead partner for Forensic and Custody Healthcare. This report will provide an analysis of the provision of healthcare services in the custody centre and consequently makes recommendations for both Police Scotland and the NHS Board / HSCP.

[2] HMICS & HIS, National baseline review of healthcare provision within police custody centres in Scotland, 31 January 2023.
[3] HIS, Framework to Inspect healthcare provision within police custody centres – interim version.
[4] HMICS, Custody Inspection Report - Lanarkshire, 20 April 2023.

Whilst recommendations outlined in this report have specific relevance for the Dundee custody centre, we recognise that some of these will be equally applicable to other custody centres across Scotland and should be taken into account in improvement planning by Police Scotland's Criminal Justice Services Division (CJSD). We consider recommendations two and eight from this report to have such relevance.

In the course of this inspection, we have found common themes that featured as recommendations or areas for improvement in the aforementioned report on custody services in Lanarkshire. We have referenced these within the body of this report where relevant.

The inspection was unannounced and took place in March 2023. As part of our inspection, we reviewed the Police Scotland National Custody System (NCS) computer database, viewing a representative selection of 42 out of the 690 detainees processed at the custody centre during January 2023. We assessed the physical environment, including the quality of cells, and observed key processes and procedures relevant to police custody operations. We also spoke with people detained at the custody centre during our inspection and interviewed custody staff and healthcare professionals at the centre during our visit.

This report highlights the need for the healthcare provider to share written information with the custody centre in respect of detainee care plans and healthcare interventions and to review the pathway for secondary mental health assessments for detainees in collaboration with partner organisations. We have also highlighted the need for improvement in the efficiency of the booking-in process and transfer practice at the custody centre and for additional training and awareness raising to be provided to custody staff to enable them to better understand the complex issues and challenges experienced by people detained in custody.

HMICS inspections are based on an inspection framework that ensures a consistent and objective approach to our work.[5] The framework consists of three overarching themes which are based on EFQM[6] principles: Leadership and Vision, Delivery and Outcomes. Each theme is supplemented by a range of indicators setting out what we expect to find during an inspection. Our custody inspections have a particular focus on service delivery and outcomes.

Police custody has been subject to considerable scrutiny by HMICS since Police Scotland was established. Since 2013, HMICS has published several custody inspection reports, the findings from which can be found on our website.[7] Police Scotland has made considerable progress in implementing previous recommendations and improvement actions in respect of custody services and are actively working to address those that remain outstanding.

Our inspection contributes 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 detainee treatment and conditions. HMICS is one of several bodies making up the NPM in the UK.[8]

In terms of next steps, we have developed a custody inspection programme for 2023-2024 in partnership with HIS. This will comprise three joint inspections to be undertaken throughout the year, the first of which has commenced at the primary custody centres in Dumfries and Galloway, which will be the subject of a future report.

We wish to thank the officers and staff of the Criminal Justice Services Division and NHS Tayside staff for their assistance during our inspection. The inspection was carried out by Ray Jones, Lead Inspector at HIMCS, with support from HMICS and HIS inspectors

Craig Naylor
His Majesty's Chief Inspector of Constabulary
July 2023

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[5] HMICS, Inspection Framework, March 2023.
[6] EFQM, Organisational Change Management.
[7] Our custody inspection reports are available on our website at www.hmics.scot.
[8] For more information about the UK NPM, visit www.nationalpreventivemechanism.org.uk.

Key findings

- Staff working at the custody centre in Dundee were professional and respectful towards detainees and those we spoke to stated that they had been treated well by custody staff.

- Despite the custody centre being within an older part of the custody estate, the physical environment was in reasonable condition. Cells were largely in good order, functional and cleaned regularly.

- The custody centre had an unconventional split-level design which comprised an administration office and charge bar located on the ground floor adjacent to a fully operational public enquiry counter, integrated with an internal staff enquiry counter. Custody cells were located at basement level.

- The split-level arrangement led to challenges regarding effective liaison between staff, staff supervisors and coordination of processes as well as accommodating those with accessibility needs.

- The requirement for custody staff to attend and manage the public enquiry counter impacted on their ability to prioritise custody operations within the centre.

- There were adequate custody staffing levels at the time of our inspection, which included designated CJSD staff at all levels. We observed a good balance of male and female custody staff at the centre.

- All operational cells in Dundee were equipped with fully functional and effective CCTV systems that could be observed within a dedicated CCTV observation room and the custody staff office.

- Cells did not have in-cell hand washing facilities. Instead, communal sinks were available in four out of five corridors. Two discrete showers were also available.

- None of the cells were fully compliant with current equality legislation in respect of accessibility. Cells located in corridors 3, 4 and 5 contained higher level sleeping plinths, however few had lowered in-cell call buttons.

- Despite previously functional segregation arrangements, cells were no longer formally segregated albeit efforts were made for juvenile detainees to be located in separate corridors wherever possible.

- Our review of a sample of records on the National Custody System (NCS) highlighted that 50% of detainees in our sample spent less than 12 hours in custody with 33% detained for less than six hours.

- We found strong practice in place in respect of vulnerability risk assessments, all of which reviewed within our sample of NCS records were accurate based on available information. Designated observation levels corresponded well to the vulnerability risk assessments.

- Our review of NCS records showed that a healthcare professional was assessed as being required in 38% of the cases within our sample. And in all but one case, NCS records indicated that a healthcare professional had contact with the detainee. We consider this to most likely be as a result of a recording error rather than a gap in service.

- Whilst custody staff had undertaken the required custody training course, those we spoke with had not undertaken any additional specialist training, for example, relating to substance use issues, mental health and trauma informed care.

- The provision of onsite healthcare within the custody centre worked well and was used effectively to maximise detainee wellbeing through effective collaboration with custody staff and external healthcare providers.

- NHS staff were provided with mandatory training as outlined in NHS Tayside, Angus HSCP and the forensic medical service induction protocols. Whilst healthcare staff had an awareness of human rights, there was no specific human rights-based training provided to healthcare staff, such as on the Istanbul Protocol.

- The separate IT systems including the police National Custody System and NHS Adastra system did not permit direct information sharing. Healthcare staff predominantly provided verbal updates to custody staff regarding detainee care plans and interventions rather than providing a written record.

- There was limited information available regarding how a detainee could make a complaint or give feedback on the healthcare service they received within the centre.

- Clinical examinations were carried out in a dedicated medical room. The door was generally kept open with a member of custody staff outside unless the examination was of an intimate nature. In some circumstances, this limited confidentiality for detainees.

- Healthcare practitioners (HCP) were responsible for cleaning the medical room however, the appropriate cleaning material was not being used to clean the clinical hand wash sink in line with current NIPCM guidance.

- Cleaning of the cells and custody area was completed by an external company whose staff informed us that there were sometimes problems with obtaining an adequate supply of chlorine based cleaning products.

- All HCPs, and some police custody officers, had been trained and had access to Naloxone when this was required. On occasion, HCPs were required to chaperone the Forensic Physician for offsite examinations, resulting in occasional gaps in Naloxone provision capacity within the custody facility.

- There was suitable fire safety signage throughout. Cells were equipped with a smoke detector linked to an indicator panel clearly visible at the charge bar. Fire alarm tests were carried out weekly, however, we found no evidence of full fire drills, including evacuations, being carried out.

- Healthcare practitioners triage and assess patients' mental health within custody. However, inspectors were told that there was no clear and agreed process in place for accessing secondary mental health assessments. This was particularly apparent for those requiring assessment for admission to hospital.

- Person Escort Record forms (PER) were completed when transferring a detainee to another facility. These did not always contain full and detailed information regarding detainee health issues potentially relevant to transport service providers. Custody staff took information for these forms directly from NCS, however healthcare staff would invariably provide verbal updates to custody staff regarding medical matters thus leaving gaps in the handover of potentially valuable information.

- Posters and leaflets signposting detainees to community support services were visible throughout the custody centre. Healthcare staff had processes in place to link in with community pharmacies, community mental health and substance use services where required for continuity of care.

- Following several years of reducing custody volume, national throughput increased by 3.5% in the financial year 2022 2023. Throughput levels in Dundee increased by almost 10% on the previous financial year.

- Criminal Justice decision making in terms of ensuring that arrest was necessary and proportionate was consistent and of a good standard. This also applied to ongoing reviews and disposal decisions and, in each instance, we found that a rationale had been recorded on NCS.

- The booking-in process at the custody centre was less efficient than it could be. This was impacted by the physical separation between processing areas and cells, however was also a result of system access issues and protocols put in place in response to the layout of the facility.

- There was no suitable space on the ground floor to accommodate strip searches which necessitated a bespoke process within Dundee to undertake these on the basement level of the facility and retrospectively amend the NCS. This process led to gaps in the recording of completed searches.

- We observed that in some cases, detainee’s personal property was not listed in their presence, nor did they sign to confirm the accuracy of the record. This could result in complaints being made by detainees.

- The provision and recording of detainee rights were completed to a high standard. However, where detainees sought the services of a solicitor prior to interview. there were omissions in recording.

- The carrying out of cell visits and provision of meals was of a good standard as was the recording of this on the NCS. We found limited reference, within our review of NCS records, to detainees being offered a wash or shower. However, our onsite inspection indicated that this was most likely to be a gap in recording rather than the process not taking place.

- Within our records review we found one use of level 4 close proximity observation and no use of level 3 CCTV observation. There were 12 cases where level 2 enhanced observations were used. In each of these cases, observation levels were well-matched to the identified risk and were reviewed and de-escalated with an appropriate rationale recorded.

- GEOAmey staff were required to pass through the police custody centre cells area to access Dundee Sheriff Court cells in order to escort individuals remanded to prison through to court. There was limited accommodation in the Sheriff Court cells which could, at times, lead to significant delays in taking custody detainees from police cells to court.

- The custody centre kitchen, although intended for sole use as a custody food preparation area, was being used by staff for personal food preparation thus presenting potential food safety / cross contamination risk.

Recommendations

Recommendation 1

Police Scotland should review and amend booking-in processes and facilities at Dundee custody centre to improve the efficiency and effectiveness of the process.

Recommendation 2

Police Scotland should ensure that clear lines of accountability are defined and stipulated for custody supervisors in the event of an adverse incident resulting in serious harm to a detainee.

Recommendation 3

Police Scotland should ensure that the recording of strip searches at Dundee custody centre provides an accurate reflection of practice.

Recommendation 4

Angus HSCP should ensure that healthcare staff working within custody centres are trained in relevant human rights protocols.

Recommendation 5

Angus HSCP should ensure that written care plans are provided to the custody centre, which include information on the outcome of the healthcare referral and any relevant intervention.

Recommendation 6

Angus HSCP should ensure that staff follow national guidance for cleaning sanitary fittings in accordance with national infection control guidance.

Recommendation 7

Angus HSCP should review the pathway for secondary mental health assessments with partner organisations to ensure that adequate arrangements are in place.

Recommendation 8

Police Scotland should collaborate with healthcare providers to ensure that relevant health related information is recorded on detainee’s escort records.

Areas for improvement

Areas for improvement	Page number
The custody centre should ensure that property handling guidance and practice is followed to avoid property challenges.	27
The custody centre should ensure that all solicitor consultations and interviews with detainees are recorded accurately on the national custody system.	28
The custody centre should ensure that all decisions to issue a detainee with anti-harm clothing are well-evidenced and reflective of risks as well as detainee needs and rights.	32
The custody centre should ensure that staff use other facilities within the station to maintain the integrity of the food preparation area for people in custody.	34
Angus HSCP should ensure that detainees are made aware of how to provide feedback or raise a complaint regarding the healthcare service they received while in custody.	37
The custody centre should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.	39

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. CJSD is led by a Chief Superintendent who reports to an Assistant Chief Constable and in turn, to the Deputy Chief Constable for local policing. Custody is delivered in accordance with the custody standard operating procedure, which is updated and amended regularly to reflect changes in practice guidelines and expectations.[9]

2. Whilst custody throughput volumes have been in steady decline since the implementation of the Criminal Justice (Scotland) Act 2016 (the 2016 Act),[10] the last financial year saw a slight increase. Table 1 below, outlines Police Scotland annual custody throughput figures from 2018-19 to 2022-23. There are a number of contributory factors for the previous reduction in throughput over recent years. This can, in part, be attributed to Police Scotland's proactive approach to divert people away from custody centres when it is considered safe and appropriate to do so. However, the moderate 3.5% increase in national custody throughput for the period 2022-2023, could be attributed to a post-pandemic return to more routine and expected operational practice in policing. Current throughput figures remain considerably lower than pre-pandemic levels.

3. Custody centres in Scotland are organised into clusters, each led by a Cluster Inspector. The custody centre we visited during this inspection, Dundee Police Custody Centre, is the sole full-time custody centre servicing the Sheriffdom area of Tayside which incorporates North East Fife. The centre forms part of the West Bell Street police station complex. The custody centre, originally opened in 1977, has over the years been subject to some structural modernisation to improve facilities, however, remains an ageing facility with notable operational challenges associated with its split-level layout.

[9] Police Scotland: Care and welfare of persons in police custody - Standard Operating Procedure (2022).
[10] Criminal Justice (Scotland) Act 2016.

4. The overall cell capacity is 40 cells, however only 37 were routinely used for detainee accommodation with the remaining three re-purposed as storage, strip search and dry-cell facilities. Dundee custody centre annual throughput from April 2022 to March 2023 totalled 7,278 with an average monthly figure of 606 (See Table 2). This represents an almost 10% increase on the previous year following four years of sustained reduction. This trend is consistent with the national pattern.

5. The cluster also includes an Ancillary Custody Centre based in Perth, however at the time of reporting this centre did not process detainees and was outwith the scope of this inspection and therefore not visited by inspectors.

6. Angus Health and Social Care Partnership (HSCP) is the lead partnership for Forensic and Custody Healthcare. It is responsible for the delivery of healthcare in custody and forensic medical testing in the Tayside police custody cluster, which includes Dundee custody centre. Nursing staff were available onsite 24/7, with a minimum of one nurse on day and night duties. A Forensic Physician was available on call.

7. Custody staffing arrangements at the time of our inspection included suitably designated CJSD staff at all levels. There were a small number of backfill staff from local policing being utilised during our visit. There were three police constable vacancies and four Criminal Justice Police Custody and Security Officer (CJPCSO) vacancies, which were subject of an active business case for replacement pending executive approval. We observed a good balance of male and female custody staff at the centre.

8. Each staff team was typically made up of a police sergeant (PS) police constable (PC) and eight CJPCSO staff, which included a CJPCSO team leader as part of each staff team. These teams were collectively supervised by a Custody Cluster Inspector.

9. The presence of both a police sergeant and CJPCSO team leader, who effectively occupy the same ranking level in terms of authority and chain of command, meant that the supervision function was split, with PCs being line managed by the sergeant and CJPCSO's by the team leader.

10. The custody centre had a split-level design, which separated processing areas and cell location. The split-level arrangement has led to challenges regarding effective liaison between staff, staff supervisors and the coordination of processes that have impacted on the efficiency of processes. We provide further details on this in the Outcomes section of this report.

11. At the time of our inspection, all staff observed the CJSD 222b[11] shift pattern, which was introduced in February 2023. Discussion with staff indicated that the recent change from a four-team to a five-team model was welcomed and was reported to have reduced staff fatigue. Some members of staff believed that the change had resulted in a reduction of staff on duty and impacted workloads.

Table 1 – National custody throughput

Year	2018-19	2019-20	2020-21	2021-22	2022-23
Throughput	118,418	115,126	101,203	93,967	97,381

Table 2 – Custody centre cell capacity and throughput

Custody centre	**Number of cells**	**2021-22**	**2022-23**
Dundee	37	6,620	7,278

Independent custody visitors

12. 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.[12] 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's NPM.

[11] The CJSD 222b pattern relates to custody staff working two early shifts, two late shifts and two nights, followed by four non-working days.
[12] Police and Fire Reform (Scotland) Act 2012, Chapter 16.

13. Independent custody visitors attended Dundee custody centre approximately once per week during the year prior to our inspection to discuss care and welfare issues with detainees. HMICS have used information regarding any recent issues identified by independent custody visitors during their visits to inform our understanding of detainee experiences.

Methodology

14. HMICS and HIS undertook a wide range of activities during our joint baseline review of healthcare provision in custody to inform the development of our custody inspection methodology. These activities are outlined in the aforementioned joint report published in January 2023. As a result, the following key stages have been undertaken for this inspection and will from a basis for future joint inspections.

15. In advance of the onsite inspection, we requested information on throughput at the custody centre in order to analyse a sample of this on the Police Scotland National Custody System (NCS).

16. On the first day of the inspection, HIS issued a letter to the NHS board to request the provision of key pieces of evidence relevant to healthcare provision. The letter also requested a follow-up meeting with NHS managers to enable the inspection team to discuss key issues arising from the onsite inspection and the evidence review.

17. Inspectors from HMICS and HIS were onsite at Dundee custody centre on two consecutive days in March 2023. During the custody inspection, we examined the treatment of, and conditions for, detainees. 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.

18. Inspectors reviewed data recorded on the NCS relevant to throughput at Dundee custody centre during the month of January 2023. This period was selected as it was within a close and relevant timeframe to our planned inspection. Total throughput for the centre during January 2023 was 690. A 6% sample was selected as it provided a proportional representation of detainees and would allow for manageable analysis. In total, 42 records were selected and reviewed.

19. 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.

20. The review of NCS records provided valuable information on aspects of risk assessment, observation levels, and compliance with the expectations of the Police Scotland care and welfare of detainees, standard operating procedure.[13]

[13] Police Scotland: Care and welfare of persons in police custody - Standard Operating Procedure (2022).

Outcomes

Custody centre condition and facilities

21. The Dundee custody centre had an unconventional split-level layout which comprised of an administrative office, charge bar and reception area located on the ground level of the police station adjacent to a fully operational public enquiry counter and internal staff counter both of which were attended by custody staff. Custody cells and a custody staff office were located at basement level.

22. The staff office was spacious, tidy, well-lit and air conditioned with five workspaces in the central floor area and an additional two workspaces in separate small offices utilised by custody sergeants.

23. The general condition of the centre was good, despite it being an older asset within the custody estate. The facility was clean and reasonably well maintained. Where there was a need for minor repairs, these were found to be subject of remedial action by staff and had been highlighted to the maintenance service for follow up.

24. We noted that custody staff were routinely required to attend the public enquiry counter during the course of their duties, which included undertaking detainee booking-in processes and providing care and welfare for detainees. It was evident that this responsibility could serve as a distraction from other key duties and impacted on their ability to prioritise custody operations within the centre.

25. We examined the route into the facility, including the external parking area / yard, which exclusively served as the custody centre vehicle dock. The dock was of ample size and could accommodate two large custody vehicles and two additional police vehicles. The dock is serviced by an access road restricted by signage to police use only and was secured against unauthorised entry by an electronically controlled roller shutter gate. The area is segregated from the main station car park and was viewable from multiple integrated CCTV cameras.

26. The holding area in the centre was spacious, secure and fitted with both audio and visual recording equipment and multiple, well-positioned affray strips.[14]

27. The charge bar contained two separate processing stations alongside a corner located processing area used for the release of detainees. These standing workspaces were elevated from the custody side floor level affording good views of the area and were separated by small vertical partition screens. The presence of retro-fitted Perspex safety screens resulted in a degree of obstruction to clear communication and detainee privacy as they were not equipped with voice holes or speech amplifiers.

28. As indicated, cell blocks are located on the basement level. These are underneath the rear yard area and can be accessed either from a door leading from the charge bar or from an alternative door situated at the end of an access ramp from the yard. Both doors lead to a landing and caged stairwell with four flights of stairs which lead to the criminal justice interview rooms and then to the cell block.

29. The multi-level footprint of the centre requires staff and detainees to negotiate a winding stairwell when moving from the custody charge bar to the cells, which could result in potential risks when escorting detainees. This arrangement also leads to practical difficulties including accommodating those with physical access needs whom, owing to the lack of alternatives to the stairs, require to be escorted outwith the custody footprint to use the staff lift to get to and from the basement level.

30. The interview rooms on the basement level were bespoke, well lit, spacious and ventilated containing a secured interview desk with hygiene screen and secured chairs. The rooms had two hopper windows requiring the use of two hands to operate a release mechanism. They were not covered by the custody CCTV system and had no integrated affray strip provision.

31. The CCTV observation viewing room, also located at basement level, was spacious, artificially lit and air conditioned. It contained three screens capable of displaying multiple feeds for individual viewers and could be partitioned to afford three discrete viewing screens. The room was not equipped with an affray strip.

[14] Affray strips are fitted throughout custody centres (and other facilities) and are used to trigger an alarm, which will initiate a response from other officers to assist at the location where the alarm is activated.

32. In general, the split-level design of the centre affords very limited scope for modifications or physical enhancements. For example, the cells staff office was located within the central service corridor of the cell block. This was relatively cramped and featured an adjoining, windowless albeit air-conditioned room, which served the dual function of locker room and staff rest area. Discussion with custody staff suggested that a business case had been submitted to seek approval for renovation of existing rooms elsewhere in the footprint to accommodate a bespoke staff rest facility.

33. In respect of first aid provision and training, all staff had undertaken this at initial recruitment and participated in annual updates through officer safety inputs and supporting online Moodle[15] packages. First aid kits were available at the charge bar, kitchen and washing areas. A defibrillator was stored in an accessible and visually obvious location immediately behind the charge bar.

34. There was sufficient, clearly visible and practically located fire safety signage, emergency lighting and materials located throughout the custody centre. This included fire safety warden specific guidance in a clearly marked location. Each cell was equipped with a smoke detector linked to an indicator panel clearly visible at the custody staff offices.

35. There were multiple clearly marked emergency exits covering all areas within the footprint. Fire tests were being carried out weekly however, this did not include the physical evacuation of detainees. The custody centre has the autonomy to decide when it is suitable to do this based on an assessment of risk and the needs of the detainees in custody at any given time.

36. 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 that report stated that **Police Scotland should ensure that a full evacuation of custody centres is undertaken in accordance with fire safety regulations**. Whilst this has relevance for Dundee custody centre, we do not intend to make an additional recommendation on this.

[15] Moodle is an online training platform utilised by Police Scotland.

Condition of cells

37. The cells block comprised 37 operational cells equally distributed across five cell corridors in the basement level of the custody centre. The cells were of older construction with those in two corridors featuring low-level sleeping plinths, which could pose a challenge for individuals with mobility difficulties. Three corridors contained higher level plinths, however these would not be considered to fully meet accessibility standards. There were no hearing loop facilities available for detainees who may benefit from them.

38. All cells were in generally good condition and were clean and functional. None of the cells had in-cell hand washing facilities, however processes were in place for staff to manage this as effectively as possible utilising the available communal sinks in each of the corridors or, when required, two shower rooms which offered adequate, discrete washing facilities.

39. All cells were equipped with thin mattresses that offered little in the way of comfort or insulation, particularly in cells with lower plinth beds. The centre should consider upgrading these wherever possible.

40. In-cell lighting was provided via natural skylights and high mounted lamps that provided a somewhat dimmer but nonetheless safe, functional and adjustable light source. All but three of the cell doors were of contemporary construction, fitted with three position service hatches, vertical louvered vision panels for improved range of view and discrete checks and were fitted with slam locks. Three of the cells originally utilised as observation cells featured doors comprising two reinforced glass panes separated by a service hatch panel housed within slam locking doors.

41. All cells had a single call button located above the toilet which operated as a two-way intercom linked to the main custody office.

42. Despite the five-corridor footprint of the facility affording capacity for separating men and women detainees, there was no indication that the centre utilised the space to do so. However, efforts were made to separate juvenile detainees from the main population wherever possible. It was positive to note however that custody staff made decisions on cell allocation based on consideration of risks and vulnerabilities.

43. There was good CCTV coverage throughout the custody centre footprint. All cells were equipped with high mounted CCTV cameras which afforded unobstructed views of the entire cell space. The footage from these cameras was routed to the custody staff office, where it could be viewed in various configurations on one of two well-positioned large screen televisions affording an uninterrupted view for staff within the office. In addition, the footage is routed to a separate dedicated CCTV observation room located in a nearby part of the custody centre that can be used by staff to observe detainees as required.

44. We found no obvious ligature points within cells. Ligature cutters were stored at the custody charge bar and additional sets were worn by some members of custody staff on their belts. Custody staff were undertaking weekly cell checks in order to monitor the condition of cells and raise any issues regarding maintenance.

Arrival at custody and booking-in process

45. We observed detainee booking-in processes over the course of two days, which included different staff members and teams. In circumstances where the custody centre had been contacted by local policing to inform them that they were bringing a person into custody, standard checks were made by custody staff in the main office prior to their arrival through the NCS and other police information systems including PNC, CHS, iVPD[16] and citations. These pre-arrival checks were carried out thoroughly by custody staff.

46. Local policing officers can undertake systems checks in advance of arrival at the custody centres. Whilst they have access to PNC and CHS on handheld devices, these are not linked to the NCS and therefore information that may be relevant to custody is not pre-populated on the system.

47. We noted issues affecting the efficiency of the booking-in process including those involving arresting officers as well as the layout of the facility, existing processes and staff practice.

[16] Police National Computer system (PNC); Criminal History System (CHS), interim Vulnerable Persons Database (iVPD).

48. Upon arrival at the centre, an arresting officer is required to leave their colleague with the detainee, either in the holding room or in a police vehicle, in order to attend at the custody office to complete a form with information required for the booking in. The officer would then attend at the custody sergeant's office to discuss the circumstances of the arrest. This process appeared time consuming and resulted in detainees waiting with just one officer for an additional period.

49. We assessed the average waiting time relevant to the booking-in process during our review of NCS records. We reviewed 40 of the initial sample of 42 records as two detainees had been transferred to hospital on arrival. Of those reviewed, the average wait time was 35 minutes, which is longer than the national average (wait time was taken as being between the arrival time and the authorisation time recorded on the NCS). This is the period before which the booking-in process can begin.

50. Booking in of detainees was primarily conducted by CJPCSOs and, in some cases, the constable who had carried out the initial background checks. In order to access systems, it was necessary for custody staff to log off from their terminal in the main office and then log in to a computer at the charge bar to carry out the booking-in process. Custody staff would then create the custody record by pre-populating information gathered on the required form before calling the detainee forward. This process of logging in and out of systems appeared to create unnecessary delays.

51. Custody sergeants and CJPCSO team leaders essentially occupied the same ranking level in terms of authority and chain of command. Both have supervisory responsibility for staff and report to the Cluster Inspector. In terms of function, sergeants make the required criminal justice decisions and team leaders have responsibility for the care and welfare of detainees though in the absence of a team leader, the sergeant carries this responsibility.

52. As a result of the aforementioned split-level custody centre arrangements, we found that CJPCSOs and custody PCs working within the cell block were supervised by the team leader while custody sergeants, based next to the custody office, supervised the staff working upstairs. During our inspection, there appeared to be limited interaction between supervisors, however we were assured that regular conversations between supervisors took place routinely during shifts.

53. Custody sergeants would routinely approve the initial risk assessment made by custody staff prior to a detainee being escorted to the basement level cells. Information relevant to this is shared between supervisors via radio or telephone. Inspectors noted that investigating officers were required to take the care sheet, which has the observation level stated on it, with them from the charge bar to the cell area, when lodging a person into custody.

Recommendation 1

Police Scotland should review and amend booking-in processes and facilities at Dundee custody centre to improve the efficiency and effectiveness of the process.

54. We spoke with sergeants and team leaders (referred to in this report as custody supervisors) about their respective roles and responsibilities in relation to the operation of the custody centre. We found that custody supervisors were clear about the distinction between their responsibilities in relation to decisions on criminal justice matters and the care and welfare of detainees. However, they were less clear regarding the lines of responsibility for the management of risk. Should, for example, an incident occur that results in serious harm to a detainee, the lines of accountability for sergeants and team leaders were not clearly defined. We consider that the Criminal Justice Services Division should give further consideration to this issue in order to ensure that, should an adverse incident occur resulting in serious harm to a detainee, clear lines of accountability are in place for sergeants and team leaders.

Recommendation 2

Police Scotland should ensure that clear lines of accountability are defined and stipulated for custody supervisors in the event of an adverse incident resulting in serious harm to a detainee.

55. We noted from our review of NCS records that the test of necessity and proportionality of arrest was applied correctly by sergeants and was suitably recorded. Subsequent criminal justice decision making including disposal decisions was good and, in each case reviewed, was considered to be correct.

56. Language identifier posters were clearly positioned at charge bars. Interpreter contacts were available to CJPCSOs, though not utilised during the inspection. Custody staff made appropriate enquiries regarding any literacy needs that a person may have and provided information on support available. There was no health-specific signage to provide information to detainees on what healthcare services may be available to them.

57. All detainees were the subject of a standard search at the charge bar by investigating officers. A handheld metal detector wand and Ampel Probes (large tweezers) were available and were used as required. These searches were conducted respectfully and were compliant with relevant standards.

58. There was however, no private room on the ground floor within which to conduct a strip search. In circumstances where a strip search had been authorised, the detainee required to be escorted downstairs to the cell block for the search to be completed. As a result of national custody system requirements, it was then incumbent upon custody staff working downstairs to retrospectively amend the search category on the system and include the authorising sergeant's name. We found that this was not being undertaken consistently resulting in gaps in NCS records regarding searches. This meant that in some cases, it was not clear what type of search had been conducted or if indeed a search had taken place.

Recommendation 3

Police Scotland should ensure that the recording of strip searches at Dundee custody centre provides an accurate reflection of practice.

59. During standard search procedures at the charge bar, detainees' personal property is taken and placed on the counter. During our observation of practice, in each instance the detainee was escorted downstairs to the custody cells before any money was counted or any item was logged onto the NCS. The detainee was therefore unable to observe the documenting of their property or sign a record to verify it as correct. On one occasion, property was left unattended on the charge bar whilst the staff member briefly visited the sergeant's office.

60. Detainees' property was stored in an open plastic container behind the charge bar and a white board was updated to cross reference the container number with the detainee. Whilst there was good quality CCTV coverage of the charge bar, the process of not recording and securing property in the presence of a detainee increases the potential for a complaint to be made.

Area for improvement

The custody centre should ensure that property handling guidance and practice is followed to avoid property challenges.

61. Custody staff were responsible for taking fingerprints and DNA samples including the onward submission of criminal justice samples to the laboratory. Custody staff were also responsible for undertaking Nexus[17] checks in relevant cases. Processes observed during our inspection were undertaken effectively.

Legal rights

62. Custody sergeants routinely made well-informed and collaborative decisions on the requirement for detention in custody. They also gave due consideration to the length of time detainees spent in custody and whether or not it was necessary for an individual to be placed within a cell during their detention. This meant that a number of individuals brought to custody were processed at the charge bar and released on an undertaking to appear at court on a later date. Similarly, other individuals were being brought to custody for interview and released thereafter.

63. From our review of detainee records on the NCS, we found that in eight of the 42 records examined the detainee was not placed in a cell. Just over 50% of detainees spent less than 12 hours in custody and 33% were detained for less than six hours. In eight cases, the detainee was held for more than 24 hours but on each occasion this was due to being held over a weekend awaiting appearance at court.

[17] Operation Nexus is a joint initiative between the Home Office and Police divisions across the UK to verify the immigration status of, and gather information from, foreign nationals, including EEA nationals.

64. The recording of the provision of rights was complete in all instances together with the offer of a letter of rights (a leaflet provided to detainees to advise them of their legal rights). There was evidence of an 'easy read' version and foreign language letter of rights being supplied when appropriate. Staff explained detainee rights clearly and methodically and checked understanding. When necessary, staff used language that was more easily understood. Intimation was sent to a solicitor of the individual's detention in 32 (76%) cases and notification to a reasonably named person was requested and completed in 12 instances (29%).

65. We noted that in a few instances, where consultation with a solicitor was requested prior to interview, there was no satisfactory update on the NCS to explain whether a consultation had occurred or if a solicitor had attended. Whilst we anticipate that this was most likely to be a recording issue rather than a gap in solicitor contact, consultations and interviews that take place with detainees should be recorded by populating the custody contact and custody movement pages on the national custody system.

Area for improvement

The custody centre should ensure that all solicitor consultations and interviews with detainees are recorded accurately on the national custody system.

66. Appropriate Adults provide communication support to vulnerable victims, witnesses, suspects and accused persons, aged 16 and over, during police investigations. Local authorities are responsible for ensuring the availability of Appropriate Adults across Scotland. The Appropriate Adults service was not used for any detainee during our inspection.

67. An interpreter was required in one of the cases we reviewed. Unfortunately the contracted interpreter service was unable to provide an interpreter with the correct language skills within a reasonable timeframe and noted that this could take up to 18 hours. This necessitated a delay in custody and a 12-hour extension was granted, given that the individual faced an allegation in respect of a serious matter.

Risk Assessment and Care Plans

68. During the booking-in process, a risk assessment is carried out for everyone that comes into police custody. People are asked a range of questions by custody staff, based on a vulnerability questionnaire. The purpose of the questionnaire is to identify if the person has had past or present issues in relation to their physical and mental health, substance use, self-harm, suicidal ideation or other vulnerabilities. Effective risk assessment is vital to ensure that detainees can be managed and cared for appropriately.

69. The initial risk assessment process allows custody staff to determine a care plan for detainees. This involves determining whether the person presents a high or low risk and putting a corresponding level of observation in place. The approach is based on an assessment of risk, threat and vulnerability. Responses to the vulnerability questionnaire and the subsequent care plan are recorded on NCS. Based on the outcome of the risk assessment, detainees are subject to observations and rousing[18] according to the following 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.

- **Level 2 enhanced - intermittent observations**. This is similar to Level 2 but with the addition of CCTV observation of the detainee in their cell, with images appearing on a monitor in the staff office. This allows for periodic checking but falls short of requiring an officer to constantly view a monitor.

[18] 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.

- **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.

70. During onsite inspection we noted that initial risk assessments were made by the custody sergeant prior to the detainee being taken downstairs to the cell area. Thereafter, the care and welfare of the detainee, including any subsequent risk assessment or change to the care plan, was managed by the team leader.

71. The sample of 42 records reviewed on NCS included 34 males and 8 females, the majority of whom were aged between 30 and 59 years of age. The sample also included two young people under the age of 18 years and one under 15 years.

72. Our assessment of the quality of risk assessments and resulting care plans is based on a combination of the review of detainee records and observation of practice during the onsite visit to the custody centre.

73. Vulnerability questionnaires had been completed in all relevant cases within the sample. The vulnerability of 24 detainees was assessed as high and 16 detainees from were assessed as low. We considered these assessments to be well-considered and accurate in all cases, based on the information available.

74. Observation levels were amended after an appropriate period to a lower level in 12 cases; mostly from level 2 enhanced to level 1. Each was supported by a suitable rationale and appeared appropriate. Overall, the quality of recording and decision making in this regard was of a high standard.

75. The majority (52%), of detainees were subject to observation levels 1 and 2. In contrast with practice in some custody centres in Scotland, there was no use of level 3 CCTV observations. Instead, the previously described level 2 enhanced observations were used. Just over 30% of detainees within our sample were initially placed on this level. Only one person was placed on level 4 close proximity observations.

76. Local policing officers that we interviewed during the inspection, indicated that they were frequently required to carry out constant observations and were, at times, required to undertake CCTV observations. They stated that they understood the requirements of the role and that the facilities were suitable. As highlighted from our review of NCS records, we found infrequent use of constant observations and the level of CCTV observations was at a considerably lower level than that found within other custody centres that we have inspected.

77. Our analysis concluded that the observation levels selected by custody staff corresponded well to risks identified through the assessment process. Consistent with previous custody inspections, over half of the detainees in our sample indicated that they had previous or current mental health issues. A third had previously attempted self-harm or suicide. This reflects the considerable level of vulnerability of many of those detained in police custody and highlights the challenges faced by custody staff with care and welfare responsibilities. It also highlights the need for ongoing engagement and planning with support service providers at a local and national level.

78. In addition to setting an observation regime, supervisors have an additional option to mitigate risk, particularly regarding self-harm, in that they can remove clothing and provide anti-harm clothing where necessary. In our review of records, clothing was removed in nine cases and in all of these, decisions were based on a risk assessment that included self-harm or suicide as an identified risk.

79. During our onsite inspection, we noted that this practice appeared to have become more commonplace. Whilst the consistent use of risk assessment processes underpin the decision to issue a detainee with anti-harm clothing, we found that the practice had become more routine in some circumstances as supervisors opted for anti-harm clothing as a risk mitigation option. We noted that this was the case in circumstances where the identified risk of self-harm or suicide was historical. We consider this to be an issue for ongoing consideration by the custody centre to ensure that decisions are well-evidenced and reflective of risks as well as detainee needs and rights.

Area for improvement

The custody centre should ensure that all decisions to issue a detainee with anti-harm clothing are well-evidenced and reflective of risks as well as detainee needs and rights.

80. It is essential that once an observation level is decided upon, custody staff undertake cell checks as required and record these on the national custody system. The custody centre did not have access to digital tablets for contemporaneous recording in the cells and therefore staff must make a note of the time and response made when checking detainees. On return to the office, staff are required to update NCS retrospectively. We found that staff were undertaking this task effectively and that recording was of a good standard.

81. Custody staff had undertaken a standard custody centre training course, which included officer safety and ICT training. This provided staff with the knowledge and skills to undertake custody centre duties including the observation of detainees in accordance with the aforementioned levels identified through risk assessment. For some custody staff, this training was long-standing, and had not been refreshed throughout their time in the role. Whilst we found custody staff to be confident and competent in their role, we identified gaps in the provision of more recent training / awareness raising inputs.

82. As in previous inspections, custody staff informed us that they had not undertaken any additional specialist training relating to the vulnerabilities common to detainees. This included, for example, training relating to substance use issues, mental health, learning difficulty, hidden disability, trauma informed care and moving and handling. Staff indicated that they had received basic guidance on undertaking physical observations regarding detainee alertness / level of consciousness during cell checks but would benefit from additional instruction.

83. 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 4** from that report stated that **Police Scotland should ensure that custody staff receive regular custody update training / awareness raising relating to substance use issues, mental health, trauma informed care and undertaking detainee observations**. Whilst this has relevance for Dundee custody centre, we do not intend to make an additional recommendation in this regard.

Detainee care

84. During our inspection we spoke with twelve people detained in custody to gain their views on their experience of custody. All stated that they felt they had been treated well by custody staff. They said that staff had been respectful and that they were offered food, drinks and snacks as required. They informed us that they felt safe within the setting.

85. Cells were mostly in good order, functional and cleaned regularly. The ambient temperature within individual cells at time of inspection was adequate, albeit this was not directly controllable by local staff but was instead maintained off site by request. There was an ample supply of toiletries and feminine hygiene products, and the facility had sufficient stores of variously sized and regularly laundered, anti-ligature clothing and bedding.

86. The kitchen, although intended for sole use as a custody food preparation area, was being used by staff for personal food preparation thus presenting potential food safety / cross contamination hazards. This was acknowledged by custody supervisors and was noted for further consideration and action.

Area for improvement

The custody centre should ensure that staff use other facilities within the station to maintain the integrity of the food preparation area for people in custody.

87. Showers were made available to detainees daily before court and anytime on a Saturday and Sunday. Only a small number of detainees within our records review sample were recorded as having taken showers.

88. There were no designated facilities for outdoor exercise for detainees. Our review of custody records found that no detainees within our sample were recorded as having had exercise. Dundee custody centre had a spacious and secure vehicle dock at the rear of the facility. With due consideration being given to potential risks, this area could be utilised for short periods to provide access to outside space, particularly for detainees subject to extended periods in custody.

89. Almost half of detainees within our sample of records had been assessed by custody staff as requiring a strip search. The majority of these had been authorised appropriately, however our review of records found that a search undertaken in respect of a child did not include a record of the required endorsement of a Police Inspector as required by Police Scotland policy. As previously stated in relation to gaps in recording on NCS, we anticipate that this may have been a recording issue rather than an authorisation issue. No detainees within our sample had been subject to an intimate search. The use of force was not recorded as having been used in respect of any detainees within our sample.

90. We found a good stock of reading material for detainees, albeit much of this was ageing and in need of replacement. This was acknowledged by custody staff and subject of a previously arranged replenishment request.

Healthcare

91. Angus Health and Social Care Partnership (HSCP) is the lead partnership for Forensic and Custody Healthcare. It is responsible for the delivery of healthcare in custody and forensic medical testing in the Tayside police custody cluster which includes Dundee custody centre. Nursing staff are available onsite at the centre 24/7, with a minimum of one nurse on day and night duties. A Forensic Physician is on duty during the day and available on call as required 24/7.

92. At the time of inspection there were no nursing vacancies, but plans were in place to recruit to future posts for maternity and retirement cover. Inspectors were told that there were generally no delays recruiting to vacant posts.

93. There is no nationally agreed waiting time standard for healthcare assessment of individuals detained in police custody centres across Scotland. However referrals made from Police Scotland to healthcare are triaged and seen as soon as possible. Waiting times can vary depending on the number of people in custody, the nature of the assessment and the number of nurses on duty. The current national electronic system for recording healthcare data across all custody centres in Scotland (Adastra) does not provide sufficient functionality to enable clinical data to be appropriately recorded, monitored and reported. As a result, reliable data for patient waiting times for access to healthcare are not available.

94. Our inspection of healthcare provision focused on the health and wellbeing of detainees as set out in the Healthcare Improvement Scotland (HIS) interim inspection framework. During the inspection, HIS inspectors spoke with custody staff and with the healthcare practitioners co-located at the centre. Inspectors assessed the treatment room, healthcare practitioner accommodation and observed key custody processes within the centre.

95. Inspectors liaised with NHS Tayside in addition to external Subject Matter Experts who provided specialist healthcare opinion based on their area of expertise such as pharmacy. Inspectors also spoke with detainees during the inspection regarding their experience of healthcare.

96. NHS staff are provided with mandatory training required for their roles as outlined in the NHS Tayside employee induction and orientation policy and Angus HSCP induction and the forensic medical service induction. While healthcare staff had an awareness of human rights, there was no specific human rights-based training provided to healthcare staff, such as on the Istanbul Protocol[19] to support the effective investigation and documentation of any torture or other ill-treatment. Human rights-based training can help participants to proactively respect and protect fundamental rights.

Recommendation 4

Angus HSCP should ensure that healthcare staff working within custody centres are trained in relevant human rights protocols.

97. We found that arrangements were in place to support communication and information sharing between NHS Tayside and key stakeholders. Clinical governance processes were in place including monthly meetings between the custody cluster inspector and the senior charge nurse. Governance of the healthcare team is discussed within the Angus HSCP Clinical, Care & Professional Governance and the service specific Business & Governance meetings. Monthly quality assurance and exception reports are reviewed to determine compliance with training, supervision, complaints and Datix (risk management information system) reporting. Service improvement is also discussed at these meetings. Forensic and custody healthcare are subject to quarterly performance reviews by the Sexual Assault Referral Coordination service (SARCS).

98. NHS Tayside is responsible for collating and managing data regarding adverse events and potential risks as well as information on complaints from detainees. NHS boards use Datix, a risk management information system, to record this information. Senior NHS managers are required to review Datix entries to identify any patterns or trends and assess whether any immediate action is needed to ensure patient safety. Learning from Datix adverse events is discussed at the bi-monthly Business & Governance meetings. We found that healthcare staff at the Dundee custody centre were utilising this process effectively and had recorded adverse events appropriately.

[19] OHCHR, Istanbul Protocol, 2004.

99. Incident records were reviewed during the inspection with evidence of associated action and learning shared within team meetings. Information on how to complain was limited to a poster within the healthcare clinic room. We did not see evidence that detainees were informed how to make a complaint about the healthcare service received nor did we see information about how to complain or give feedback on the service in different formats or languages. At the time of inspection there had been no complaints submitted within the past year.

Area for improvement

Angus HSCP should review its process to ensure that detainees know how to provide feedback or raise a complaint regarding the healthcare service they received while in custody.

100. A number of audits were undertaken by NHS Tayside to monitor practice and to drive improvement. This included audits of record keeping, prescribing, infection control, monitoring of alcohol brief interventions and the number of healthcare assessments carried out.

101. Inspectors noted that prior to a person arriving at the custody centres, custody staff made an initial assessment of healthcare needs based on information available from electronic records and, in some circumstances, from local policing. Where it is identified that a person has significant healthcare needs, such as a physical injury, they would be taken directly to hospital for assessment and then transferred to the custody centre when deemed fit. In circumstances where it is less clear that hospital treatment may be required, the individual is brought to custody for assessment.

102. Inspectors were told that there were good working relationships in place between custody healthcare staff and healthcare staff at the local hospital. New doctors working within A&E routinely visited the custody centre to develop awareness of the range of healthcare provided within custody.

103. Patient healthcare needs were identified through a vulnerability questionnaire completed by custody staff when people were brought into custody. If this triggered a referral for healthcare, custody staff would complete and send an electronic referral to the healthcare team. Detainees could also request to see healthcare staff at any point during their detention. Information regarding healthcare was included in the letter of rights that was given to detainees. Custody staff informed us that having onsite healthcare professionals supported their decision making in referring detainees to the healthcare team.

104. A monthly dashboard system was in place to record data including the number of referrals received by forensic and custody nurses (FCN), as well as transfers to A&E and forensic complainant examinations.

105. Referrals received by healthcare staff were dated and timed upon receipt and triaged based on clinical need and workload. The separate electronic systems used by custody staff and NHS staff to record custody data are unable to connect with each other to share information. Custody staff use the National Custody System (NCS) to record information relevant to detainees, whereas NHS staff use ‘Adastra.’

106. While Adastra has the functionality to print a record of the patient’s care plan, inspectors were told this does not consistently happen in practice and more often key information is exchanged via verbal handovers provided by HCPs to custody staff that they then transfer onto NCS as required. The custody staff we spoke with were concerned about the potential for gaps or inaccuracies in healthcare information to emerge as a result of this procedure as they were not provided with a written account of the outcome of the healthcare referral.

Recommendation 5

Angus HSCP should ensure that written care plans are provided to the custody centre, which include information on the outcome of the healthcare referral and any relevant intervention.

107. Healthcare assessments were documented in freehand on a standardised template and recorded on the Adastra system. Inspectors saw that assessments were generally well completed and covered previous and current physical health, addictions and mental health issues where relevant.

108. Clinical examinations were carried out in a dedicated medical room. The door was generally kept open with a member of custody staff outside the room. This was highlighted as being for safety and security reasons, unless the examination was of an intimate nature. Where a risk assessment has identified risk then this is of course considered to be acceptable. However, custody staff should consider individual circumstances to a greater extent in order to ensure that, wherever possible, detainees are able to meet with a HCP for assessments and other health related interventions in privacy and therefore maintaining their confidentiality.

Area for improvement

The custody centre should ensure that detainee healthcare interventions are undertaken confidentially unless a risk assessment indicates otherwise.

109. The medical room and equipment were visibly clean and in a good state of repair. Flooring, surfaces and the ceiling were intact ensuring effective cleaning could be carried out. An appropriate chlorine-based cleaning product was available for use on blood and body fluid spillages. HCPs were responsible for cleaning the medical room, however the appropriate cleaning product was not being used to clean the clinical hand wash sink in line with current national infection control guidance (NIPCM).[20]

Recommendation 6

Angus HSCP should ensure that staff follow national guidance for cleaning sanitary fittings in accordance with national infection control guidance.

[20] National Infection Prevention and Control Manual https://www.nipcm.scot.nhs.uk/.

110. Cleaning of the cells and custody area including the management of blood or body fluid spillages was completed by an external company. Cleaning staff informed us that a chlorine-based product was used to clean the cells and sanitary fittings, however there were, at times, difficulties in obtaining an adequate supply of the product.

111. As noted within our report on the inspection of custody centres in Lanarkshire, it is important that an adequate supply of the correct chlorine based cleaning products are available within custody centres in order to ensure adherence to national standards. **Recommendation 8**, from that report stated that **Police Scotland should ensure that environmental cleaning standards are maintained within medical rooms in line with clinical standards**. We consider that this recommendation has relevance across the custody estate including Tayside and therefore do not intend to make a further recommendation on the matter.

112. Medical equipment such as the blood pressure monitor was visibly clean and in good condition. Healthcare staff told us that it was cleaned daily and between patients, which inspectors saw evidence of in practice. Hand hygiene facilities were available and healthcare staff were seen to carry out hand hygiene appropriately. Personal Protective Equipment such as masks were available, however were not being used by HCPs during our visit. Guidance at the time of inspection strongly recommended that healthcare staff wear a facemask when delivering direct care as this supports good infection control. We highlighted this during the inspection and the issue was subsequently addressed.

113. Sharps bins used to dispose of used needles were managed appropriately. Clinical waste bins were available and were not overfilled. Clean linen, laundered by an external company, was stored separately from used linen, which was securely stored while awaiting collection. NHS Tayside provided external assurance around infection prevention and control and highlighted that the lead nurse for the HSCP carried out assurance walk rounds, the last one being in February 2023.

114. Emergency equipment, including oxygen and an automated external defibrillator was available and well organised, with regular checks being completed. Emergency medications were readily available and in date. HCPs were trained in intermediate life support and received yearly updated training. Systems and processes were in place along with emergency equipment to manage medical emergencies safely.

115. Inspectors observed a health assessment being undertaken, which was carried out in a professional and supportive manner with a holistic approach to the detainee's healthcare needs. Staff were aware of the process for identification and documentation of injuries allegedly sustained as a result of force. Due to staffing constraints, detainees could not request specific healthcare staff to carry out health assessments. Although there was ramp access to the custody centre, none of the cells were fully compliant with current equality legislation[21] in respect of accessibility for people with mobility challenges. Healthcare staff told us that they provide advice to police custody staff regarding how best to support detainees with disabilities and what assistive equipment may be of benefit.

116. There were clear processes in place for managing medicines and healthcare staff used these to safely prescribe, administer, record and store medicines. A process was in place to order medications including controlled drugs. Healthcare staff told us that a pharmacist visited regularly to safely destroy out of date or no longer required controlled drugs. Inspectors saw that controlled drug registers were completed well. Healthcare staff told us that a controlled drug license was in place.

117. Various methods were used to ensure robust medication reconciliation, including checking electronic records and speaking with the patient's usual pharmacist. This ensured that patients received their usual medication whilst detained, including any Opiate Substitution Therapy (OST).

118. OST continued whilst the patient was detained and was generally given to patients at the same time each day. Patients suffering from alcohol or tobacco withdrawals received appropriate detox medication including nicotine replacement therapy if required and appropriate tools were used to monitor withdrawals.

[21] The Equality Act 2010.

119. Most of the healthcare staff were non-medical prescribers and prescribed all medications except methadone, which was prescribed by a Forensic Physician. Inspectors were told this was embedded practice in partnership with local community substance use services for safe prescribing of methadone despite non-medical prescribers having competence to prescribe. Inspectors understood there were rarely delays to patients receiving methadone as timely prescriptions were obtained from Forensic Physicians. However, the HSCP informed us that they are planning to review the prescribing process.

120. The Scottish Government's Medication Assisted Treatment (MAT) standards were published in May 2021. These are evidence-based standards, introduced to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. All organisations responsible for the delivery of care have a duty to work towards implementing the MAT standards and to ensure that staff are suitably prepared to meet their responsibilities. NHS Tayside staff had an appropriate awareness of MAT standards.

121. Harm reduction interventions were available to detainees with some nurses trained in motivational interviewing, alcohol brief interventions and low intensity psychology interventions.

122. Custody staff were not trained to administer Naloxone, however all HCPs were trained and had access to Naloxone 24/7. On occasion, nurses were required to chaperone the Forensic Physician for offsite examinations, resulting in occasional gaps in Naloxone provision capacity within the custody facility.

123. 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 15** from that report stated that **Police Scotland should ensure that Naloxone is available within custody centres and that it can be administered during times when healthcare professionals are not available**. Whilst this has some relevance for the Dundee custody centre, we do not intend to make an additional recommendation on the matter.

124. HCPs had responsibility to triage and assess patients' mental health within custody. However, inspectors were told that there was not a clear agreed process for accessing secondary mental health assessments, if these were required. This was particularly apparent for those requiring assessment for admission to hospital. Despite concerted efforts by custody healthcare teams to work with secondary care colleagues, there could be a lack of joint working which resulted in lengthy waits for people to be seen, assessment and admitted to hospital in the cases where this was considered necessary.

Recommendation 7

Angus HSCP should review the pathway for secondary mental health assessments with partner organisations to ensure that adequate arrangements are in place.

125. Fitness for release assessments were undertaken by the Forensic Physician or nurses at the centre where there was a risk of harm or identified vulnerabilities. Inspectors were informed that the Nursing Global Assessment for Suicide Risk (NGASR) would be completed in respect of a fitness for release assessment, with the resulting score being recorded on Adastra. We found that this process was being followed appropriately. Inspectors were told that custody is rarely used as a place of safety under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

126. When a detainee is transferred from a custody centre to another facility, a Person Escort Record (PER) form is completed by custody staff. At the Dundee custody centre, these did not always contain full and detailed information regarding detainee health issues that may potentially be relevant to transport service providers. Custody staff took this information directly from NCS, however healthcare staff would invariably provide verbal updates to custody staff rather than a written record regarding medical matters thus leaving gaps in the handover of potentially valuable information.

Recommendation 8

Police Scotland should collaborate with healthcare providers to ensure that relevant health related information is recorded on detainee's escort records.

127. Posters signposting detainees to community support services were visible throughout the custody centre. Healthcare staff have processes in place to link in with community pharmacies, community mental health and substance use services where required for continuity of care. Leaflets were also provided to people on release. A 'road recovery map' was displayed and available for detainees to take away. This listed a range of activity-based mental health, substance use, health & wellbeing, harm reduction, peer support and family support services available in the community.

128. Dundee custody centre benefits from the services of a third sector agency called Positive Steps, which provides ongoing support for people with alcohol and drug dependency. A Positive Steps worker attends at the custody centre each morning to visit detainees, and all are asked if they would like to be referred, which captures those who may not be present when the worker visits. The service provider offers a face-to-face meeting and a signposting and referral service to detainees regarding community support for vulnerable adults. We consider this to be good practice and a proactive example of support provided to detainees to access appropriate community supports, including healthcare, when released from custody.

Detainee transfers

129. GEOAmey are the escort provider contracted to transfer detainees from Dundee Police Station to the appropriate Sheriff Court and then to facilitate their release or transfer to prison. They also escort individuals from prison to court in order to appear as required.

130. Dundee Sheriff Court is set adjacent to the police station and their respective cells are connected by an underground corridor. We found that arrangements were in place for detainees from custody, as well as those being transported to and from prison by GEOAmey staff, to enter and leave court via the custody centre cells area through the aforementioned corridor. It appeared unusual that remand prisoners, for whom the police custody centre had no responsibility or legal role, were escorted through the custody cells area in order to attend and leave court.

131. Dundee police station generally processes all detainees arrested in the Tayside area and also those within North East Fife, an area that falls within the Dundee Sheriffdom. Whilst there were occasions when a detainee required to be transferred to another jurisdiction, those held at Dundee are generally required to appear at Dundee or Perth Sheriff Court.

132. GEOAmey staff attend the police custody cells each morning to ascertain which detainees require to be transferred to Perth Sheriff Court. Unless there are necessary delays for a detainee to undergo a medical examination, it was found that the transfer to Perth was usually swift and efficient.

133. GEOAmey has limited accommodation within Dundee Sheriff Court. There were a number of court cells that can accommodate up to five detainees. Detainees presented for court by the police cannot be mixed with remand detainees from prison. If a detainee is categorised for segregation, they must be alone in a cell and high risk or violent detainees are not placed in a shared cell. Dundee sheriff Court generally holds its custody court during the afternoon, which allows time for case preparation.

134. As a result of these arrangements, there can be delays in the escort of police custody detainees to the Sheriff Court cells early in the morning, which means that detainees remain in custody cells for longer periods. During our inspection, the transfer of detainees was reasonable, with a steady transfer throughout the morning however, staff suggested that particularly on a Monday, when the custody court is busy, detainees can remain in police custody well into the afternoon before being transferred to the Sheriff Court cells.

135. Staff explained that delays in the transfer of detainees to court causes secondary issues for Police Scotland as custody cells can remain full throughout the day, which significantly reduces capacity for new business, sometimes adding pressure to local policing.

136. The situation can also impact on healthcare as there is a requirement for additional provision of medication and medical care throughout the day. It can affect the routine management and maintenance of the custody centre as processes including the cleaning of cells and laundry collection can be delayed and adversely affected. Similarly, custody staff are required to provide care and welfare for detainees for extended periods in these circumstances.

137. Detainees being released from police custody were escorted by staff from the cells on the lower level to the charge bar on the ground floor, where pre-release risk assessment questions were asked prior to release. There was a laminated sheet containing relevant questions available to staff to ensure they were completed correctly. This process was found to be conducted thoroughly and recorded satisfactorily.

138. During our inspection, custody staff reported that, on occasion, individuals released from court without means to return home, were directed by court based staff to visit the Police Station for support and/or the provision of funds. We would suggest that this is a matter for local policing in Dundee, the Court and local service providers to address.

Virtual Court

139. Virtual court (VC) facilities were available at the custody centre though these were not in use at the time of our inspection. The system was located in one of three solicitor consultation rooms and was only used in the event of a detainee with Covid-19 being required to appear at court. If used, there was a requirement for this to be staffed by GEOAmey. No issues of concern were raised regarding this facility.

Police Constable-led custody centres

140. Police Constable-led (PC-led) custody centres were introduced following extensive review and trials of the process undertaken as part of a custody transformation process. PC-led custody centres have become an integral part of the overall National Custody Operating Model.

141. The premise of the PC-led model is that suitably trained, experienced and approved Police Constables, who have the ability and confidence to perform the duties of Custody Officer, take the lead for coordinating onsite custody operations under the remote supervision of a custody sergeant. They will therefore provide guidance for custody staff as required and provide authorisation for detention and liberation in line with criminal justice legislation and guidelines.

142. At the time of the inspection there was no use of PC-led custody centres in the Tayside area, however during discussion with the Area Commander and Cluster Inspector, they described plans to consider limited opening of Perth custody centre in the future. If implemented, it would be remotely supervised from Dundee and would take low risk business that would otherwise be directed to Dundee.

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